DOCUMENT RESUME

ED 390 558 PS 023 859

AUTHOR	Fenichel, Emily, Ed.
TITLE	Zero to Three, August/September 1995.
INSTITUTION	Zero to Three/National Center for Clinical Infant Programs, Arlington, VA.
REPORT NO	ISSN-0736-8086
PUB DATE	Aug 95
NOTE	41p.
AVAILABLE FROM	Zero to Three, 2000 14th Street North, Suite 380, Arlington, VA 22201-2500 (1-year subscription, $37).
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Zero to Three; v16 n1 Aug-Sep 1995
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Child Health; Childhood Needs; Health Needs; Health Personnel; *Health Services; *Infant Care; *Pediatrics; *Primary Health Care
IDENTIFIERS	Family Support; Zero to Three

ABSTRACT

This issue of "Zero to Three," the bulletin of the National Center for Clinical Infant Programs, focuses on pediatric primary care. Articles include: (1) "Expanding the Boundaries of Pediatric Primary Care to Support the Development of Infants, Toddlers and the Families" (Linda Eggbeer); (2) "Providing Information and Support for Parents in Pediatric Primary Health Care Settings: An Interview with Bernard Levy" (Linda Eggbeer); (3) "Group Well-Child Care as a Method of Providing Developmental Guidance in Pediatric Primary Care Settings" (Lucy M. Osborn); (4) "Pediatric Pathways to Success: The Power of Pediatric Practice To Support Families" (Margot Kaplan-Sanoff); (5) "The Soho Parenting Center: A Model for the Integration of a Parenting Service into a Pediatric Practice" (Lisa Spiegel and Jean Kunhardt); (6) "The Touchpoints Model: Building Supportive Alliances between Parents and Professionals" (Ann C. Stadtler and others); (7) "Bright Futures: Health Supervision Guidelines and Their Implementation" (Morris Green and Meri McCoy-Thompson); and (8) "Keys to CaregivinG: A New NCAST Program for Health Care Providers and Parents of Newborns" (Georgina Sumner). The issue also includes reviews of publications and videos. (JW)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

10729

ZERO TO THREE

National Center for Clinical Infant Programs

August/September 1995 Volume 16 No. 1

ED 390 558

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

X This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Expanding the Boundaries of Pediatric Primary Care To Support the Development of Infants, Toddlers and Their Families

Barbara Bundy

PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

E. Fenichel

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Linda Eggbeer, M.Ed.
Director, Developmental Specialist in Pediatric Practice Project, ZERO TO THREE/The National Center, Arlington, Virginia

How can our nation use its resources most wisely to reach and support parents of infants and toddlers at a time when help is likely to count the most? Through what systems or mechanisms that currently exist can we most efficiently and effectively reach large numbers of caregiving adults with new information about the potential capacities — and vulnerability — of their children during the first three years?

ZERO TO THREE believes that one possible answer to these questions might lie in this country's health care system — particularly in primary pediatrics. Primary health care settings, including private pediatricians, health maintenance organizations (HMOs), and community health centers are in many ways natural settings for joining with and supporting the parents of very young children. This article will describe ZERO TO THREE's work in exploring the potential of pediatric primary care for expanded services that emphasize the tremendous importance of parents as their chil-

continued on page 3

PS 023859

BEST COPY AVAILABLE

Editor's Note

Providing developmental guidance and support to parents of young children in the context of primary pediatric care is an idea whose time has come -- over and over again, it seems, without ever becoming established (in this country at least) as the standard of care. Contributors to this issue of *Zero to Three* explore: the importance of attention to social and emotional development and anticipatory guidance as a key ingredient of children's health supervision; the barriers to enhancement of primary pediatric care; innovative approaches to change, in settings that serve both privileged and highly stressed parents and their children; and a wide range of educational materials (for professionals and families) that reinforce conversations between health care professionals and families about the development of infants and toddlers. Although the current turmoil of our country's health care system is troubling in many respects, it is possible that from the flux will arise a new model for pediatric primary care -- one which not only nurtures all aspects of the healthy development of young children but also supports adults as they become increasingly competent and confident parents.

Emily Fenichel, Editor

Contents

1 Expanding the Boundaries of Pediatric Primary Care To Support the Development of Infants, Toddlers and Their Families
Linda Eggbeer

8 Providing Information and Support for Parents in Pediatric Primary Health Care Settings: An Interview with Bernard Levy
Linda Eggbeer

10 Group Well-Child Care as a Method of Providing Developmental Guidance in Pediatric Primary Care Settings
Lucy M. Osborn

12 Pediatric Pathways to Success: The Power of Pediatric Practice to Support Families
Margot Kaplan-Sanoff

18 The Soho Parenting Center: A Model for the Integration of a Parenting Service into a Pediatric Practice
Lisa Spiegel and Jean Kunhardt

24 The Touchpoints Model: Building Supportive Alliances Between Parents and Professionals
Ann C. Stadtler, Maureen A. O'Brien and John Hornstein

29 Bright Futures: Health Supervision Guidelines and Their Implementation
Morris Green and Meri McCoy-Thompson

33 Keys to CaregivinG: A New NCAST Program for Health Care Providers and Parents of Newborns
Georgina Sumner

36 Publications

37 Videotapes

Zero to Three Staff

Editor, *Emily Fenichel*
Consulting Editors, *Jeree Pawl and Jack Shonkoff*
Assistant Editor, *Videotapes, Margie Wagner*

Zero to Three is the bi-monthly bulletin of ZERO TO THREE/The National Center. All rights reserved. To obtain permission for academic photocopying (for course packets, study materials, etc.) of ZERO TO THREE materials by copy centers or university bookstores, contact: Academic Permissions service, Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, tel: (508) 750-8400, fax: (508) 750-4744.

ISSN 0736-8086

© 1995 ZERO TO THREE/The National Center

2000 14th Street North, Suite 380, Arlington, VA 22201-2500
Tel: (703) 528-4300
Publications orders: 1-800-899-4301

ZERO TO THREE/The National Center
Board of Directors
Kathryn E. Barnard, *University of Washington*
T. Berry Brazelton, *Children's Hospital Medical Center, Boston*
Maria D. Chavez, *University of New Mexico*
Robert N. Emde, *University of Colorado School of Medicine*
Linda Gilkerson, *Erikson Institute, Chicago*
Stanley I. Greenspan, *George Washington University School of Medicine*
Robert J. Harmon, *University of Colorado School of Medicine*
Irving B. Harris, *Pittway Corporation, Chicago*
Asa Grant Hilliard,III, *Georgia State University, Atlanta*
Gloria Johnson-Powell, *Harvard Medical School*
Sheila B. Kamerman, *Columbia University School of Social Work*
Anneliese F. Korner, *Stanford University Medical Center*
J. Ronald Lally, *Far West Laboratory, San Francisco*
Bernard Levy, *New York City*
Alicia F. Lieberman, *University of California, San Francisco*
Samuel J. Meisels, *University of Michigan, Ann Arbor*
Dolores G. Norton, *University of Chicago*
Robert A. Nover, *George Washington University School of Medicine*
Joy D. Osofsky, *Louisiana State University Medical Center, New Orleans*
Jeree H. Pawl, *University of California, San Francisco*
Deborah A. Phillips, *National Research Council, Washington, D.C.*
Kyle Pruett, *Yale University School of Medicine*
Arnold J. Sameroff, *University of Michigan, Ann Arbor*
Marilyn M. Segal, *Nova University, Fort Lauderdale*
Rebecca Shahmoon Shanok, *Jewish Board of Family & Children's Services, New York City*
Jack P. Shonkoff, *Brandeis University, Waltham, Massachusetts*
Lynn G. Straus, *Mamaroneck, New York*
Ann P. Turnbull, *University of Kansas, Lawrence*
Bernice Weissbourd, *Family Focus, Inc., Chicago*
Serena Wieder, *Silver Spring, Maryland*
G. Gordon Williamson, *JFK Medical Center, Edison, New Jersey*
Barry Zuckerman, *Boston University School of Medicine*

Life Members
Mary D. Salter Ainwsorth, *University of Virginia*
Peter Blos, Jr., *Ann Arbor, Michigan*
Peter B. Neubauer, *New York City*
Arthur H. Parmelee, *University of California Medical Center, Los Angeles*
Julius B. Richmond, *Harvard University Medical School*
Mary Robinson, *Morgan State University, Baltimore*
Pearl L. Rosser, *Silver Spring, Maryland*
Albert J. Solnit, *New Haven, Connecticut*
Edward Zigler, *Yale University, New Haven*

Executive Director, Matthew Melmed
Associate Directors, Carol Berman, Emily Fenichel, and Haida McGovern

This publication was made possible in part by a grant from Johnson & Johnson Consumer Companies.

BEST COPY AVAILABLE

Expanding the Boundaries of Pediatric Care . . .

continued from page 1

dren's primary nurturers. We will share some of what we learned from individuals across the country who are also committed to this idea and have developed innovative approaches to addressing it; examine barriers that need to be overcome and attributes that can be built on to realize the potential of pediatric settings; describe new ways of conceptualizing health supervision; and identify important questions and next steps.

Pediatric primary care as a venue for reaching parents

In order to pursue its interest in primary prevention and parent support, ZERO TO THREE secured a two-year grant (1994-96) from the Bureau of Maternal and Child Health (MCJ#517394) which it combined with already committed funds from a private donor who had long been interested in an enhanced role for the health care system in getting babies and parents off to a good start (see interview with Bernard Levy, this issue). The overall goal of the Developmental Specialist in Pediatric Practice project is to explore how pediatric settings might become more responsive to the needs of a broad spectrum of parents. We are particularly interested in helping to expand the definition and practice of pediatrics, so that it more closely reflects the broad health supervision guidelines called for in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (Green, ed., 1994; see Green and McCoy-Thompson, this issue), which calls for new health supervision policies and practices in keeping with the pervasive changes that have occurred in families and our society as a whole.

We have approached this work with the following assumptions:

1. Care in pediatric settings is likely to benefit from a multidisciplinary, rather than an exclusively medical, approach.

2. Mutual and respectful partnerships between the health system and parents are critical to efforts to rear young children who achieve their full potential in all domains of development.

3. Parenting information and support should be available to all parents, with special, more intense services offered to those who need them.

4. There are many ways, and many people, who can bring about these changes in primary pediatric care; we want to learn all we can about how it can best be done in various settings and circumstances.

One of the first tasks project staff undertook was to learn all we could about the current status of developmental guidance in pediatric primary care. We conducted an extensive literature review along with telephone interviews with knowledgeable individuals across the country who were recommended by the project's advisory committee. Each person we talked to generously shared his or her ideas and perspectives with us and suggested other individuals whom we should contact. This process led us to medical and non-medical professionals who are providing very useful services to parents in pediatric settings across the country, some of whom have contributed articles to this issue.

We knew going into the project that the idea of enriching the developmental content of pediatric health care has had a distinguished history. As far back as 1948, Milton Senn, a pioneer in the introduction of psychodynamic concepts into pediatric practice, expressed the view that pediatricians need to develop competency in both the biomedical and psychosocial aspects of child health (Green, 1982). In 1975, T. Berry Brazelton observed:

A pediatrician interested in influencing these forces (parents) for the child's best interest must make the mother the focal point of any attempt to help the child. It is economical in time and resources to get to know her well, and if we can, it is extremely important to include the father. Their feelings about the child and their own limitations set the boundaries within which the pediatrician can expect to be effective for the child (Brazelton, 1975, p. 534).

Although the thinking of Senn and Brazelton is not often echoed in the pediatric literature, we talked to a number of individuals who share their perspective and who have tried to respond to the challenge of using the pediatric setting to broaden the knowledge and skills of young parents. Some of the services we heard about include:

- developmental assessments for all newborns in a pediatric practice;
- availability within the practice for more extensive developmental assessment on a referral basis;
- pediatricians and nurse practitioners routinely offering counseling to parents on a variety of child-rearing issues, such as feeding, sleeping, temperament, and the infant-parent relationship;

Acknowledgments: For wise counsel and steadfast encouragement, ZERO TO THREE thanks the Advisory Committee of the Developmental Specialist in Pediatric Practice Project: Cecilia Barbosa, Kathryn Barnard, T. Berry Brazelton, Constance Smith Garner, Margaret A. (Peggy) McManus, Morris Green, Stanley I. Greenspan, Bernard Levy, E. Elaine Vowels, and Barry Zuckerman. For courage and resourcefulness in exploring new frontiers, we salute Margaret Jones, M.A. and Claire Littman, LCSW. This project is supported in part by project MCJ#517394 from the Maternal and Child Health program (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

- parent groups, held during the day and evening hours, to enable parents to discuss their questions and concerns in the presence of health care or other clinicians; and
- checklists, given to parents in advance of well-child visits, to remind them of questions or areas of concern for discussion with the pediatrician.

Each of these efforts demonstrates a respect for, and an effort to support, the critical role parents play in their young children's development.

Pediatric care providers are reaching out to families in the poorest and the wealthiest of circumstances. Across all income groups, pediatric care is one of the services most often used by parents of children under three. No other institution or system exists which has more contact with children in this age group. Pediatric care does not carry the stigma associated with, for example, welfare services, substance abuse services, mental health services or any of a myriad of other services with which families of very young children may interact.

We talked with early childhood educators at New York's Bellevue Hospital who have developed what they call a "hallway" program, an innovative way of providing opportunities for young children to play and their parents to talk informally while they wait for pediatric appointments. The program professionals have an opportunity to join with parents in observing their own and other children in the group and to encourage discussion among the group of parents about any issues or questions they have. If there are concerns about a particular child, the early childhood educator discusses the possibility of additional investigation or assistance with the parent and passes along the results of her interaction with the family to the pediatric staff. Boston City Hospital, which serves a similar inner-city population of families with multiple needs, has brought together the services of a multidisciplinary team of primary care clinicians, family advocates, early childhood educators, and attorneys in order to build a strong alliance with families on behalf of their children (see Kaplan-Sanoff, this issue).

A developmental pediatrician whose practice is located in an upper-middle-class neighborhood near New York City's Central Park told us how much information and support the mothers in her practice seem to need and how insecure many of them feel about their role as new mothers. She has responded by establishing parent groups which she co-facilitates with a psychologist, to whom she also makes referrals for individual counseling and follow-up.

But it certainly must be said, and our literature review confirmed, that efforts such as these are the exception rather than the rule. It is clear that the expansion of pediatric services is an idea that has not been systematically researched, funded, or implemented in this country.

Current pediatric practice: Barriers to developmental services

Our current model of pediatric practice has remained essentially unchanged over the past 50 years: clinicians working one-on-one with a family in an office, with occasional support from a nurse or social worker (Zuckerman & Parker, 1995). Although we have experienced great success in this country in reducing contagious disease, which at the beginning of the 20th century was the primary cause of mortality and morbidity, children and families today face a whole new set of challenges. What are we really suggesting when we say that primary care settings need to provide help to parents of infants and toddlers on a variety of child-rearing issues? Are we asking pediatricians, whose stock in trade is health supervision and primary prevention, to address a whole new scope of issues? Are we asking them to accomplish an impossible agenda?

Many health professionals readily acknowledge that focusing attention exclusively on the physical realm of development, especially with infants and toddlers, does not constitute adequate care. Other pediatricians, however, resist the suggestion that they are not adequately attending to important psychosocial issues that the family brings to the practice. We had conversations with pediatricians and nurse practitioners in both categories. Zuckerman and Parker (1995) describe "retreating to the comfortable world of otitis media and immunizations... to shut out the loud cacophony of the outside world and its effects on our families" (p.761).

Three chief barriers seem to prevent health professionals from attending to psychosocial issues in the context of pediatric primary care: training, time, and money. The second two barriers are closely related.

Training: Many practicing pediatricians (other than those trained in developmental and behavioral pediatrics) have not received training to adequately address psychosocial and behavioral issues and to work in full partnership with parents. The improvement of training in the psychosocial aspects of child health has been, (Green, 1982) and remains today, an important issue for pediatric education.

Time: On average, health care providers spend only 12-15 minutes per pediatric visit. As one nationally known pediatrician put it, "Pediatricians are in an impossible bind. Their interaction (with baby and parent) is limited to what you can do while writing on paper (Aronson, personal conversation, 1994).

Money: The reimbursement policies of health insurers determine to a large extent what kinds of services pediatricians and other pediatric health care professionals provide. It is not apparent that, as a group, insurers recognize the tremendous significance of healthy growth and development in the first few years of life and the importance of ensuring that sufficient amounts of time and services are available to children in this age group

Jim Kang, Photo Agora

and their parents. Physical exams for infants and toddlers, for example, continue to be reimbursed at a lower rate than physical exams for older children — notwithstanding the unparalleled rate of development in the first three years and its tremendous impact on later development.

A report by McManus Health Policy, Inc. (in press) points out that no studies have ever been conducted to determine the extent to which private health insurance and Medicaid will reimburse parent education services offered in pediatric settings. The report observes that, to the extent that existing payment mechanisms can be used to purchase such services, the more likely they will be imbedded in primary care services and maintained over time.

Reimbursement by insurers for expanded services to parents is likely to require evidence that providing early and ongoing anticipatory guidance to parents, and behavioral and developmental surveillance to infants and toddlers in a manner suited to their needs, beliefs, and traditions, will, in fact, make a difference with respect to later healthy development. In the current health care market, the primary focus of insurers' efforts is directed toward keeping costs down.

Opportunities within a system in flux

Pediatricians and other health care providers are facing dramatic, ongoing changes in health care services and financing that create a confusing and volatile environment in which to practice. They are faced with trying to provide adequate levels of care in capitated systems and with having to decide how many and what kinds of managed care plans their practice will participate in. Many are joining large group practices in order to survive while others are joining the staffs of HMOs. With increasing national efforts by the federal government, insurers, and employers to contain health care costs, families' access to the time and expertise of health care providers, particularly pediatricians, is likely to become more, rather than less, limited.

The tremendous flux in the health care system can present an opportunity for experimenting with effective approaches to helping very young children and their parents get off to a good start. For example, staff at the Preventive Ounce, a California-based non-profit organization which seeks to enhance health education, told us about their design and evaluation of a health education program to prevent temperament-related problems among infants, toddlers, and preschoolers who receive pediatric care in Northern California Kaiser Permanente facilities. Parents of four-month-olds were invited to complete a temperament questionnaire, based on the work of Drs. Stella Chess and Alexander Thomas. The results of the questionnaire, which asks parents to comment on the frequency with which their babies engage in certain types of behavior (e.g. "reacts mildly to meeting familiar people" or "continues to cry in spite of several minutes of soothing") are converted into a temperament profile for the child. Parents are sent guidance materials about what to expect of children with different kinds of temperaments and suggested ways of responding appropriately to a child of that particular temperament. Parents are also invited to consult with temperament counselors by phone if they have additional questions or concerns.

A study of the effects of this anticipatory guidance indicated that parents who participated in the temperament program required 1.48 fewer outpatient visits in their infants' four-to-16-month age period, than parents who did not receive guidance. Savings occurred in pediatrics, family practice, and emergency room visits. This kind of initiative and the development of cost benefit data to document its effectiveness are encouraging but rare.

Within the last two or three years several important new initiatives have begun which, together with ZERO TO THREE's work, will broaden our understanding of how parents of infants and toddlers can be better served in primary health care settings. One of these initiatives, recently undertaken by the Commonwealth Fund, will establish 15 local initiatives in health care settings around the country to develop and evaluate an

BEST COPY AVAILABLE

expanded set of services to support parents of young children, to be delivered by health personnel. Maternal and Child Health and the Medicaid Bureau, U.S. Department of Health and Human Services, are launching a major initiative to encourage the adoption and use of the health supervision guidelines outlined in *Bright Futures* in health care settings across the country (see Green and McCoy-Thompson, this issue). T. Berry Brazelton's Touchpoints model, which offers parents a map of early development and helps them develop an understanding of the natural spurts and regressions that occur in the earliest years, is currently being used to train nurse practitioners in establishing partnerships with parents to support healthy development (see Stadtler, O'Brien, and Hornstein, this issue). Each of these initiatives, based on somewhat different underlying constructs about, for example, how parents learn best, will undoubtedly greatly add to our understanding of the most effective ways to be responsive to the needs of individuals parenting infants and toddlers.

ZERO TO THREE's Developmental Specialist in Pediatric Practice Project

Pediatric health care settings can, it appears, nurture alliances between professionals and parents that enable professionals to better understand the needs and priorities of individual children and families, and that enable parents to make good use of information and support. But if pediatricians do not have the training or the time to be deeply involved in this process, how will it occur? Which developmental services to infants, toddlers and parents are, in fact, the most valuable for which populations? Are services best made available on a universal or referral basis? What are the advantages and disadvantages of having medical, as opposed to non-medical, professionals working on these issues with parents of very young children? If non-medical professionals assume these responsibilities, how can they be integrated into a new role in the pediatric practice? How can we ensure that these individuals are qualified and suited to perform their roles? What are their training and supervision needs? How can services be paid for?

In order to build a first-hand understanding of the barriers and opportunities for expanding services in pediatric settings, ZERO TO THREE negotiated with two pediatric sites in the Washington, D.C. area to collaborate with us on this project. We hired two professionals, one an early childhood special educator and the other a clinical social worker, both at the masters level, to work 20 hours per week, each in one setting, and to develop the most effective services possible for parents of children under three years of age.

The process of finding two pediatric sites and hiring two developmental specialists added a great deal to our knowledge base. Staff had initial conversations with approximately ten potential sites, knowing that we wanted to locate in a private group practice and an HMO, in order to be able to examine differences in these two systems. A number of practical and philosophical barriers were identified during this stage of the project, among them lack of space to accommodate another person in the practice; concern about disruption to hectic schedules if additional services were offered; concern about how someone from another discipline would "fit in;" concern that parents would be unhappy if services were discontinued at the end of the project (September, 1996); and lack of understanding of the developmental specialist as part of the health team rather than as an ancillary professional to whom children and parents are referred.

ZERO TO THREE's Developmental Specialist project is predicated on the belief that parents themselves drive their own learning process. Parents' concerns and questions serve as the catalyst for what the developmental specialists pay attention to and how they individualize their services.

The two sites selected for the Developmental Specialist project will collaborate closely with ZERO TO THREE in exploring project questions. They are the Kaiser Permanente Pediatric Clinic in the District of Columbia, an HMO, and Sleepy Hollow Pediatrics in Falls Church, Virginia, a five-person group practice. Each site serves an ethnically and economically diverse group of families, although Kaiser serves primarily African-American families and Sleepy Hollow, primarily Caucasian families. In exchange for ZERO TO THREE's hiring, training, supervising, and compensating the developmental specialists, these two sites agreed to work closely with the project to examine the theoretical and practical feasibility of developing and imbedding services to further the healthy development of infants and toddlers in their settings. Each site has assigned one of its pediatricians as primary liaison with the developmental specialist.

The process of recruiting the two developmental specialists was a lengthy one as well. We were looking for individuals who not only possessed extensive training and experience in working with infants, toddlers, and families, but who also exhibited the capability to establish strong and supportive relationships with children and families. We searched for professionals who were reflective, who found it a challenge to take on a new role, and who we thought could use training opportunities and clinical supervision to good avail. The two individuals hired met all of our criteria.

The developmental specialists have been on-site since the end of June. In the pediatric setting, they

observe the quality of the interactions between infants and parents that support or inhibit mutual adaptation, communicate new and exciting findings about the extraordinary capacities of children under three, and provide anticipatory guidance about what is coming up in the next few months. Their job is to assist parents in the discovery of temperamental variables, coping mechanisms, and special sensitivities in their particular child. At this point in the project, the developmental specialists are trying to see as many newborns as possible in each practice, usually by accompanying the pediatrician or nurse practitioner during well-child visits. In this way, the developmental specialist is introduced to the family in a personal way, hears what the health professional and parent say to each other, and is "blessed" by the health professional as someone from whom the parent can get additional information and insight. When the pediatrician leaves the examining room, he or she may invite the parent to remain with the developmental specialist if the parent desires or to call back with questions.

The developmental specialists also respond to requests from the pediatricians or nurse practitioners to observe particular children or to work on a short-term basis with families around child development issues such as feeding, sleeping, excessive crying, and appropriate stimulation, and around parent development issues such as choosing child care, feelings of inadequacy, and balancing family and work responsibilities. Given their part-time availability, the developmental specialists will need to seek a balance between making sure that as many families as possible can avail themselves of their services and making sure that they devote time and attention to children and families for whom development does not seem to be progressing normally.

ZERO TO THREE's Developmental Specialist project is predicated on the belief that parents themselves drive their own learning process. Information about typical development and expectations for future development provide the context for learning about and developing a mutually satisfying relationship with a particular baby. The concerns and questions that parents have at any particular point in time, that flow out of their own experience, serve as the catalyst for what the developmental specialists pay attention to and how they individualize their services.

Documenting the Developmental Specialists in Pediatric Practice project

One of the central objectives of the Developmental Specialists in Pediatric Practice project is to pay attention to the experience of the developmental specialists, with children and families and as members of their respective health care teams. They are asked to spend several hours of their 20-hour work week reflecting on and recording their observations and insights into the nature of the work. They are encouraged and given time for specialized training opportunities (e.g., spending time with a hospital-based lactation counselor or observing other developmental specialists in the area). As they encounter issues or subjects about which they would like to learn more, they find or seek help in identifying appropriate training.

In addition, both developmental specialists participate, together at this point, in twice-monthly supervisory sessions with Stanley Greenspan, a child psychiatrist, and/or Serena Wieder, a clinical psychologist, to talk through issues that arise in their interactions with children and families and to explore their own feelings and reactions to the work. The supervisory sessions give them an opportunity to reflect on their evolving relationships with various members of the practice in terms of role differentiation, boundary issues, and their evolving place within the practice as a whole. They are able to brainstorm about creative ways of responding to some of the practical problems and limitations of very busy pediatric practices. The project director is in weekly contact with the developmental specialists and not only provides feedback and support on questions and issues that arise in their work but also keeps the project focused on key questions.

We expect that the project will evolve, depending on, among other things, our growing understanding of what parents need most; our exploration of the most cost-effective ways of providing what they need; the developing relationship of the developmental specialists to their individual practices; and our increasing understanding of broad health care policies and practices, particularly with respect to securing reimbursement for preventive services for infants, toddlers, and their families. This is challenging and fascinating work. ZERO TO THREE welcomes comments and insights from readers' own experiences in trying to expand the boundaries of pediatric primary care to support the development of infants, toddlers, and their families.

References

Brazelton, T.B. (1975). Anticipatory guidance. *Pediatric Clinics of North America*, 22, 3.

Green, M. (1982). Training the pediatrician in the psychosocial aspects of child health. *Zero to Three*, Vol. II, No. 4, 5-7.

Green, M. (Ed.).(1994). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Arlington, VA: National Center for Education in Maternal and Child Health.

McManus, M.A. (in press) *Opportunities To Secure Private Insurance and Medicaid Reimbursement for Parent Education.*

Zuckerman, B & Parker, S. (1995). Preventive pediatrics: New models of providing needed health services. *Pediatrics*, 95 (5), 758-762.

Providing Information and Support for Parents in Pediatric Primary Health Care Settings:
An interview with Bernard Levy

Linda Eggbeer, M.Ed.
ZERO TO THREE/The National Center, Arlington, Virginia

Bernard Levy, a retired business executive, is a founding Board member of ZERO TO THREE and currently serves as treasurer of the organization. Mr. Levy's commitment to the primary prevention of developmental problems among young children is passionate and long-standing. Fifteen years ago, in the December, 1980 issue of *Zero to Three*, Mr. Levy described to an interviewer his concern about primary prevention for infants, toddlers, and their families. He spoke about the need for parents to be helped to understand the tremendous importance of the earliest years for healthy growth and development. He called for innovative approaches to developmental and behavioral assessment of infants and toddlers, and pointed to the pediatric setting as a logical place for such enhanced services to be located.

Mr. Levy has championed the idea of bringing additional resources for infants, toddlers, and parents into primary health care settings for fifteen years. He is a major funder of ZERO TO THREE's Developmental Specialist in Pediatrics Project (see Eggbeer, this issue), which is exploring ways in which trained professionals can be effectively integrated into primary health care settings in order to assess children's emotional and cognitive development in the same time frame that pediatricians are assessing their physical development.

In this interview, Mr. Levy reviews the basis of his commitment to increasing guidance and support for parents of young children as a critical primary prevention strategy.

Why do you believe so strongly that developmental specialists in pediatric health care settings can and should be a primary source of information and support for very young children and parents?

Health care settings are, for now, the most logical, and therefore the most likely, place to capture the attention of most parents — at a time when parents are most motivated to learn about infants, and about themselves as new mothers and fathers.

When a new mother is in a pediatric setting, she's thinking "health" and she is trying to figure out what is right for her baby. She is also challenged, thinking about herself in her new role. There are lots of questions and struggles. The issue is not the development of the child alone, but also the dynamic changes taking place in the parents themselves.

I know from my own experience that mothers' and fathers' emotional well-being affects how they are as parents. These issues are hard to raise, much less deal with, in a 12-minute visit with a pediatrician who is clearly in a rush. A developmental specialist in the pediatric setting can better assess the child, assess the relationship, and help the parent understand both.

It is very important that the developmental specialist's expertise be recognized; she is not "the play lady." The pediatrician can introduce the developmental specialist to parents at the first visit by saying, "We have been looking at your baby's physical development. But it is equally important to monitor every child's emotional, social, and cognitive development. The developmental specialist has the expertise to do that. We will be working together with you."

What are you learning from your conversations with parents and business leaders about the need for enhanced services for families of very young children?

I'm learning that the level of knowledge varies enormously, among parents and business people alike. Some have a vague notion that some good should, would, or could come from enhanced services in pediatric settings — but no one can put their finger on specific outcomes. This is not as easy as identifying the benefits of immunizations. With a few exceptions, most people I talk to don't even understand that the first three years of life set the pattern that will stay with that child for life.

We have a big public education job to do. In a cost-conscious climate, we can't just say, "An ounce of prevention..." — that won't cut it with the business community and policy makers. We have to demonstrate that it is cheaper to prevent problems or treat them early. But cost is not the sole issue. We have to make the case that we have enough knowledge to help parents raise children who are emotionally, socially, and cognitively healthier — who will become healthier adults.

Do you think that many parents are getting the kinds and amount of help with parenting that they need?

I know of **no** parent who is getting the kind and amount of help in parenting that he or she really needs. Even with all the information available through parenting books, magazines, television, and talk shows, parents

© Michael Heckler

still need a specialist who can talk with them about their child, and what they bring to the business of being parents, and how it all fits — or is hard to fit — together.

Information in books and the media is helpful, but it is generic, and we are not generic parents raising generic children. Furthermore, every one of us interprets information through our own filters. That is why the developmental specialist is such a necessary ingredient — she can observe the specific parent with the specific child and meet every child and parent where they are. Anything less individualized is likely to miss the point and is not likely to be very helpful.

In your opinion, is the lack of support for parents the result of insufficient understanding of the need, insufficient money, or other causes?

I think that insufficient understanding is the key issue, with parents as well as policy makers. If you don't feel the first years of life are especially dynamic, and no support is being offered by the current system, you tend to conclude that nothing is needed. Young parents' budgets and public budgets are always squeezed. If no one is saying that parents of infants and toddlers really need individualized support and guidance, then it's not easy to get limited resources dedicated to this population.

What do you hope the Developmental Specialist in Pediatrics Project that you have funded will accomplish?

I hope that the project will:

- demonstrate that early detection will prevent developmental problems or allow intervention to begin early, before problems become so deeply ingrained that they are essentially a permanent part of a child's personality.
- demonstrate the **economic** benefit of dealing with a problem while it is small, rather than waiting until it is full-blown.
- demonstrate that proper, individualized education of parents by a developmental specialist really is an "ounce of prevention that is worth a pound of cure." It must be understood that education will not only be about infants' development, but will also be about **parents'** development.
- demonstrate that using all the strategies we have talked about, we can raise children who can learn more successfully and become adults who will function more competently and healthfully (and less violently) in our changing, challenging society. As we said in *Heart Start*, children must be emotionally ready to learn and thus eventually earn a living. They also need to be emotionally ready to face frustration without resorting to violence — in their homes or in the community. Children need to be emotionally ready to work productively with other people.

Healthy emotional development begins in the first three years. I am worried by much of what I see when I look at today's young children and their parents — how little time they spend together, how little understanding parents and policy makers have of the importance of the earliest years.

We have enough knowledge to start doing better by our children, although in future years we'll know much more. By the time you interview me again — 15 years from now? — I hope that there will be a developmental specialist in every pediatric health care setting to give parents the information and support they need, and our country's children need.

Head Start Opportunity

The National Head Start Bureau is expanding its pool of professionals to serve as peer reviewers and/or on consultant panels. Individuals who respond will automatically be placed on a mailing list to receive announcements concerning the availability of funds. Interested people should send their name and mailing address to Ellsworth Associates, Inc.; Attn Head Start Reviewers and Consultants, N-A28, 8381 Old Courthouse Road, Vienna, VA 22182; fax (703) 356-0472; E-mail cclark@acf.dhhs.gov. Applications may be submitted electronically by IBM-compatible PC users who indicate their preference for a 3 1/2 or 5 1/4' disk.

BEST COPY AVAILABLE

Group Well-Child Care as a Method of Providing Developmental Guidance in Pediatric Care Settings

Lucy M. Osborn, M.D., M.S.P.H.

Professor of Pediatrics and Associate Vice President for Health Sciences
University of Utah Health Sciences Center

A major goal for all those who work with children is to maintain or restore health. Unfortunately, in the first few crucial years of life, the only contact the majority of children routinely have with health professionals is through physicians' offices and medical clinics. Although the efficacy of what I term "office-based prevention" has been questioned, there is little doubt that wellness visits offer a unique opportunity to provide developmental guidance for families. First, most families will see a physician, nurse practitioner, or physician's assistant for several "check ups" in the first three years of life. Second, when a family brings in a child for a well visit, they are not stressed or concerned about a specific illness. They will normally be very open to working in concert with the health provider to examine the child's life, to determine the possible threats to overall health, and to cooperatively find solutions to problems.

Certainly, the most critical issues are related to children's social environment and their behavior and development. It is unrealistic to expect that a health care provider can make a truly effective intervention in the 15 or 20 minutes normally allotted for the routine well visit. During this short interval, the provider must develop rapport with the family, give reassurance, identify potential or current problems, teach, and identify obstacles to behavioral changes...a formidable task. In this era of managed health care, in which productivity of individual providers is generally measured in terms of numbers of patients seen, rather than long-term health outcomes, increasing the time spent per visit is not a feasible solution.

Group well child care is one method for increasing contact time with families without loss of time to practice. Rather than using the one-to-one format of a traditional medical encounter, the provider can schedule four to eight families at the same time. The first forty-five minutes to an hour (depending on the number of children in the group) is spent discussing health issues, normal development and behavior, social issues, and observing and evaluating the child and family in the group setting. This is followed by brief (five minute) physical examinations and administration of immunizations. Using the traditional format, the range of time required to complete individual visits would be 60-160 minutes; average time scheduled for the group is 90 minutes. I usually schedule the groups for late afternoon, so that working parents can attend. This seems to result in many more fathers attending the groups than individual wellness visits.

Increased time available for patient education is one obvious advantage of the group format. Our studies have indicated that more of the recommended content of well child visits is covered during the visits and that parents are more active participants in the group discussions than they are during individual visits. The dynamics of the group add to the value of this mode of care. Parents of similarly aged children will have shared concerns and sense that they are generally supported by the other participants. Perhaps the greatest advantage of groups, however, is the reassurance that parents feel and an increase in their self-confidence regarding their ability to manage their children's care. Group participants consistently comment that they enjoy observing the other children. They are uniformly relieved to learn that their child is not the only one with temper tantrums, or night awakening, and that other parents also feel stressed by the challenges of child-rearing.

Group care offers advantages to the provider as well. One unique feature is the opportunity to observe both the children and the parents over an extended period of time. An hour spent with six two-year-olds is an education in and of itself! As they play, the provider can see how each family copes with a range of behaviors, from friendly social interactions to temper tantrums. It is also an opportunity to model parenting behaviors, as well as to provide immediate, non-judgmental feedback to parents. One frequently occurring example is watching one child poised to hit another, taking his hand before the blow, and saying, "I can see that you are angry and want to hit Brian. That is not allowed. Why don't you tell him you're mad instead?" Although this sounds like far too complicated an interaction for young children, their responses are amazingly varied and often surprisingly positive.

Although I generally try to follow the recommended guidelines for the content of the visit, the majority of the time will be spent on social and behavioral issues. Over time, as the group becomes more cohesive, the topics become increasingly relevant and personal. An example

is a fifteen-month group in which hitting, biting, and violent behavior became a hot topic. One of the fathers was a huge, gentle man who practically lectured the group on the evils of using physical power to enforce rules or control behaviors. A second father, a refugee from Vietnam, was convinced that he needed to teach his child to "defend himself," even at this tender age. The child's mother became upset, and an argument ensued. After a few moments, I interrupted, saying that this seemed an issue that we should talk about separately. At that point, another parent exclaimed, "No, don't do that." She looked at the arguing parents and laughingly said, "I am so glad you did this. We do it all the time at home—argue about what to do—but we never do it in public. So what should we do to come to some agreement about how to handle their behavior?" The discussion that followed was both intense and, according to each of the families present, incredibly helpful and meaningful.

The discussion of family issues and behaviors and development is intense because the problems are so immediate, understandable, and visible to parents. Prevention and anticipatory guidance are two content areas that will not be spontaneously introduced by the participants. It is important to keep track of the conversation and sometimes interrupt to assure that the essential topics, such as accident prevention, receive adequate attention.

Although the group format offers many advantages, there are certainly problems and obstacles to care that must be overcome. Space and scheduling can be challenging. I have usually used a portion of the office waiting room. Because the space is relatively small and must still be used by my partners' patients, I ask that parents not bring siblings to the group visit. This not only controls the number of children present, but also avoids the disruption and distraction that siblings introduce to the group process.

Scheduling group visits requires a dedicated, patient receptionist. Prior to each group's visit, I will review the upcoming schedule with the receptionist and set a date for the subsequent group visit. She is then able to fill out both appointment and reminder cards prior to the patients' arrival. When parents sign in, they are asked to address the reminder cards, so that the address is current. These are then filed by date and sent to the families two weeks before the scheduled group. If patients cannot attend the group visit, they are given an individual appointment. These visits can be problematic for families who are accustomed to the group format. They will expect the same amount of discussion to occur during their 15-minute time slot!

The nurse who manages the group must also be committed to the concept, trained to expect all the families to arrive at once, and be able to cope with the large bursts of demands and activities that occur immediately before and after the group discussion. The first families will usually arrive prior to the appointment time. These children can be weighed and measured before the group starts. They are then put into an examination room immediately after the conclusion of the discussion. While I examine these children, the nurse will weigh and measure the others, then administer immunizations as the examinations are completed.

The group format is also not something that every provider can enjoy. One's tolerance for chaos must be relatively high! Also, the questions that are asked are often quite challenging, and frequently not easily answered. The acceptability of the group process also seems to be dependent both upon the provider's style of interaction and the population of patients seen. Group visits are not for those who are most comfortable with information giving, rather than problem solving. Some patients and providers prefer a more expert or authoritarian style than the group process will allow.

Although the barriers to changing the mode of caregiving can be large, the rewards can be equally great. The pressures created by managed care are to increase productivity. Group care certainly offers one method of meeting these challenges through increasing the efficacy of care without losing the time that is so essential for patient education and developmental and behavioral counseling. As Dr. Lawrence Nazarian stated regarding the need to address some of the difficulties in providing effective wellness care, "In the meantime, we can keep enjoying healthy babies with wet grins and bright-eyed little kids and get paid for it! Hardly anyone else is so privileged."

References

Nazarian, L.F. (1990). Pediatrician's perspective: Odd thoughts on well-child care. *Pediatrics in Review*, 11:227-228.

Osborn, L.M. (1994). Effective well-child care: A monograph on delivery of care and outcomes research. *Current Problems in Pediatrics*, 24:293-332.

Osborn, L.M. (1993). Alternatives in preventive health care: Babies in bunches. *Medical Encounter*, 10(1), 7-9.

Dodds, M., Nicholson, L., Muse B., and Osborn, L.M. (1993). Group health supervision visits more effective than individual visits in delivering health care information. *Pediatrics*, 91:668-670.

Green, M. (Ed). (1994). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Arlington, VA: National Center for Education in Maternal and Child Health.

Pediatric Pathways to Success:
The Power of Pediatric Practice To Support Families

Margot Kaplan-Sanoff, Ed.D.
Boston City Hospital

When I brought my baby to the pediatrician for the first time, I was so scared. I didn't know whether I was feeding her enough, if what she was doing was normal. I worried about the visit for a long time. I wondered whether the doctor would think I was a good mother.

It's not surprising that many new parents feel this way about their first visit to their pediatric primary care clinician with their tiny infant. As hospitals move towards increasingly earlier post-partum discharge, families bring their newborns home without the benefit of the teaching and support which they used to receive in the hospital. Often still exhausted from labor and delivery, they discover that their sleepy one-day-old is becoming more alert and demanding; he's crying and difficult to console. This becomes the first challenge for all families: learning to comfort and to understand their new baby, to gain confidence as parents to care for their child.

For the one in four babies born into an impoverished household, this challenge is compounded by limited resources and lack of access to services (National Commission on Children, 1991). Lack of money restricts a family's ability to afford adequate housing, healthy food, formula and diapers, and to live in a safe neighborhood. Many families are unaware of community programs developed to provide help and family support. Others are reluctant to ask for help for fear of involvement with child protection agencies. For these reasons, the pediatric primary care clinician is often the only professional who sees these babies on a regular basis.

These initial primary care visits provide a window of opportunity to establish a therapeutic relationship with the family and to help them access other needed services such as WIC , maternal health care, Head Start for older siblings, and literacy and job training opportunities. These early visits also offer a special opportunity to connect the family with the health care system, to establish a trusting relationship with their pediatric primary care clinician, and to understand the value of preventive health care for themselves and their children.

At Boston City Hospital, we have developed an enhanced model of pediatric primary care which uses this window of opportunity to support infant development and to provide family support. Boston City Hospital (BCH) is a large municipal hospital serving an inner-city population. Of the over 1700 babies delivered at BCH each year, 18% have been prenatally exposed to drugs, 4% are discharged to homeless shelters, 11% are premature. After delivery, mothers are routinely discharged with multiple appointments for pediatric care, postpartum follow-up, WIC, drug treatment and counseling. Not surprisingly, few families keep all of these appointments, which are often located in different parts of town, and use different staff members and different rules for scheduling visits at each site. However, what we have learned from other programs, like the Women and Infants Clinic at BCH (Kaplan-Sanoff & Rice, 1992), is that women will invariably take their newborns for pediatric care, at least for the first six months. These mothers reported that taking their baby to their pediatric primary care clinician made them feel like "good parents"; going to a drug treatment or mental health facility did not enhance their feelings of being good parents. In this way, the power of the pediatric visit is two fold: 1) it provides a window of opportunity to connect families to other needed services and 2) it is non-stigmatizing, providing parents with the opportunity to be "good" parents.

When the doctor said that she had gained almost a pound, I was so proud. I thought that maybe I was doing something right. Maybe I would be a good mom.

All parents want to be good parents for their infants. They look to their pediatric primary care clinician to tell them that they are doing a good job. When clinicians are aware of the normal anxieties of parents and respond sensitively to parents' questions and underlying concerns, they can begin to form a powerful alliance with families around issues that impact the health and development of their young children. But for the pediatric clinician, this responsibility presents a formidable challenge. The clinician is expected to provide anticipatory guidance, perform developmental surveillance, recognize and address parental issues of depression, substance abuse and domestic violence, teach safety and injury prevention, advocate with the school system and other social service agencies, manage behavioral issues and immunize children — all within the context of a 15-20 minute health supervision visit. Clearly there is a limit to the clinician's ability to address such a daunting agenda (Zuckerman & Parker, 1995).

Pediatric Pathways to Success

To help pediatric primary care clinicians meet the complex needs of infants and families, particularly those families living in poverty, Boston City Hospital initiated an enhanced medical-educational model for delivering pediatric primary care. **Pediatric Pathways to Success** strives to maximize and expand the opportunities for providing child development information and parent support during the pediatric visit. The goals of Pediatric Pathways are: 1) to support child health and development, 2) to support feelings of confidence in parents, and 3) to support the clinical effectiveness of the pediatric practice to meet the needs of children and families. To accomplish these goals, Pediatric Pathways created a multidisciplinary team of primary care clinicians, family advocates, and early childhood specialists who work directly with the family to ensure that, in addition to pediatric care, they receive the services they need. These may include WIC and AFDC, health insurance/Medicaid, information about food pantries, housing and employment, legal advocacy, drug treatment, smoking cessation programs, and maternal health care.

Pediatric Pathways also provides child development information to families through anticipatory guidance, home visits, parent handouts, and developmental surveillance. All children have "developmental check-ups" at six-month intervals. Older siblings are also included in the program with attention paid to their social/emotional and educational needs through developmental screening, enrollment in Head Start, public school, special education services and summer camp.

The role of the Family Advocates

Many families struggling with issues of poverty are so overwhelmed with the stress of daily living that they are not able to concentrate on their child's developmental needs. They are concerned about the basics—food, clothing and shelter (Frank, et al., 1991). In order to address these basic survival issues, families with a child under six months of age are met by a Pathways family advocate when they come for their well child visit. The family advocate works as part of the pediatric practice; she sees the family during the well child visits and works with the primary care clinician to assure that the needs of the family are being met, especially in relationship to the child's growth and development. For some families, the family advocate may help them apply for Medicaid or WIC benefits. For other families, she may work with the substance abuse/mental health specialist to help parents access drug treatment and child care or to encourage them to attend a twelve-step group. Once their basic needs have been addressed (even if they cannot be completely met), families tend to be more open to suggestions about their child's learning, temperament, behavioral style, and developmental needs. The family advocate provides family support during the pediatric visit by encouraging the parent to ask questions and raise concerns about the child. She listens carefully to parents, gives them developmental information about their child and provides handouts which highlight the milestones which most children will accomplish by the next visit and a list of culturally appropriate activities which parents can do with their children to help them meet those milestones.

Most importantly, because the family advocates are representative of the cultural, ethnic and racial backgrounds of the families served by BCH, they help bridge the gap between medical practice, social services, community programs and family needs. Parents will often tell the family advocate about child-rearing practices which they think the primary care clinician would disapprove of, like starting solids early by mixing cereal in the bottle. The family advocate explains the reason why the primary care clinician might not agree with the practice, but she also supports the parents' need to have their parenting approaches heard and considered. She can discuss the cultural meaning of the parents' child-rearing practices with the clinician and educate the clinician about other cultural practices related to child care. Finally, she explores whether parents have enough money for additional formula which the child may need, and she helps parents adjust their child-rearing practices to meet the needs of their children, especially in the case of children who are at risk for growth problems.

The primary care clinician and the family advocate are the core of the Pathways team. Enrollment of families into Pathways was specifically designed for families with infants under six months of age. This allows time

Table 1 Pediatric Pathways to Success: Staffing patterns and responsibilities

Team Member	Discipline	Responsibilities
primary care clinician	pediatrician; pediatric nurse practitioner	child health & development
family advocate	community worker; women's advocate; "community mom"	family support, community-based referrals, follow-up and case management
early childhood specialist	early intervention specialist; child development specialist; early childhood educator	child development information developmental assessment • family support • supervision of advocates
attorney	lawyer; legal advocate	legal issues: eligibility for WIC, SSI, etc., custody, immigration, parole
substance abuse/mental health specialist	psychiatric nurse; social worker; psychologist	maternal mental health assessment substance abuse treatment • smoking cessation • supervision of advocates

for a relationship to develop between the family, clinician and family advocate during the early well child visits scheduled at 2 weeks, one month for immunizations, 2 , 4 and 6 months as determined by AAP guidelines.

The power of this initial relationship allows the family advocate to introduce parents to the other members of the Pathways team such as the early childhood specialist, the substance abuse/mental health specialist and the attorney. Table 1 outlines the Pathways staff positions and roles for which each one is responsible. The family advocate helps parents understand the roles played by each team member. She introduces the family to the early childhood specialist who performs the developmental checkup and then works with the family and the early childhood specialist to refer children to appropriate educational programs and support services as needed. If the family advocate has concerns about parent-child interaction, she will support the intervention work of the early childhood specialist through home visits and play sessions. Similarly, if the family advocate has concerns about the parents, she will consult with the substance abuse/mental health specialist on the team to help the family address their problems. She may also support families to enter drug treatment, to obtain restraining orders against abusive partners, to seek counseling and/or medication for depression, and to attend the weekly Narcotics Anonymous group for pregnant and parenting women sponsored by Pathways. Finally, she will work with the attorney affiliated with Pathways to help families with issues of custody, immigration, denial of benefits, etc.

As the family advocate introduces the family to the rest of the Pathways team, she extends the power of the primary relationship which she has developed with the family to the other team member; she "blesses" the team members with the trust which she has established with the family. Families are more receptive to the child development information given by the early childhood specialist when they sense that "their" family advocate trusts this professional. They are also more receptive to new information when they have experienced being heard and validated by their family advocate in their concerns about their child. Parents are often willing to try different child-rearing strategies when they feel that they have already been successful in parenting their baby.

On those occasions when the family advocate determines that the family may need to have "an authority figure" set limits on their behavior, she can use the early childhood specialist or the mental health specialist to reinforce her concerns. For example, one teenage mother with a language-delayed toddler and an irritable young baby missed several well child appointments, even after the family advocate had called to remind her of the dates. When she showed up for a sick child visit several days later, the family advocate introduced her to the early childhood specialist, who was familiar with the case and was aware of the family advocate's frustration with this young mother. Instead of being introduced to the mother by her first name, which is the common practice, the early childhood specialist was introduced quite formally as "Dr. Jones". This was a clear signal between team members that the family advocate needed the early childhood specialist to set firm limits with the mother about her behavior and to explain the consequences of her behavior, both for her rather vulnerable children and for her involvement with the child protection agency. This team approach allows the fam-

ily advocate to maintain her alliance with the family as the "good provider," while using the authority of the early childhood specialist as the "tough provider." In situations like this, close communication with all team members, especially the primary care clinician, is crucial to avoid splitting of providers by the family.

Clinical supervision is therefore critical to the success of Pathways. Family advocates meet weekly with the Clinical Director and mental health specialist to discuss ongoing cases, review stressful interactions with other health care and social service providers who work with families, and reflect on the challenges of working with difficult families. Establishing boundaries between work and community and avoiding burnout have also been intense topics for supervision, since the advocates live in the same neighborhoods as the families and frequently run into families in the community on the weekends. Supervision helps the advocates set limits on their work and adjust their expectations for families. Early in the project for example, one advocate casually referred to an 11:30 PM call to her pager from a parent who wanted to talk about his frustration with finding child care for his infant son. Through the supervisory process, the advocate explored different ways to be available to parents during working hours and to set limits on parents' need to contact her in the late evening.

The role of the early childhood specialists

The early childhood specialist usually meets the family at the first "developmental checkup," at the six month pediatric visit. The early childhood specialist conducts a brief developmental screening, observes the parent-child interaction, and asks the parent(s) "how things are going at home." Although the primary purpose of the developmental screen is to determine if the child needs to be referred for early intervention or other services, it is also used as an opportunity to extend the alliance between the family and the pediatric practice. As a member of the Pathways team, the early childhood specialist reinforces how well the parents are doing at supporting their child's development, validates their concerns, and re-frames the baby's behavior within the context of normal child development. For example, parents are often embarrassed when their six-month-old puts every toy used during the screening in his mouth. This offers a wonderful opportunity to talk about how most babies mouth things to learn about them, to encourage parents to allow the baby to explore new things, to discuss parental anxiety about choking, to discuss safety precautions, and to ask parents what they thought about their baby's behavior during the screening. Developmental checkups occur during the well child visit, but it is the early childhood specialist who has the child development expertise and the time to spend with the family, allowing the pediatric clinician to attend to other patients.

The early childhood specialist explains why such seemingly unimportant tasks, like using a pincer grasp to pick up a cheerio, are important windows into the baby's development and learning. As one mother said, "when I realized that all the mess he was making with his food was really helping him to learn, I told my mother to stop worrying about the kitchen floor. My baby is learning." The parents are asked who the baby reminds them of and whether the infant's temperament and behavior were what they expected it to be. Both questions allow parents to discuss their hopes and dreams for their child as well as to raise concerns which they might have about the baby's behavior.

At every developmental checkup and every well child visit from six months on, each child is given a developmentally and culturally appropriate book to keep through the Reach Out and Read Project (Needlman & Zuckerman, 1992). When parents see how delighted the baby is with the book, how she gums it and bangs it and then settles in to look at the pictures, they are excited to see their child being "successful" at such an important task as learning to read. For parents struggling to overcome poverty, being successful in school is a powerful goal, one which speaks to the aspirations of all parents. It is a particularly important goal to parents who want their children to move out of poverty into successful jobs and better neighborhoods. By making explicit the connections between infant development and later school learning, the Pathways team seeks to mobilize parents to attend to their infant's learning and behavior.

After a developmental checkup, parents often express their wish to tell their family advocate the results of their child's developmental screening; they want to share their pride in their child with her. This marks a significant step in the parent-provider relationship, consolidating the alliance between the parent and the family advocate. It also allows the early childhood specialist and the family advocate to reinforce the powerful connection between the child's learning and the parents' child-rearing approaches. Many parents are unwilling or unable to take credit for their child's accomplishments; they are afraid to assume such an intimate relationship with their infant due to previous losses or their own childhood experiences. Pathways team members work hard to reinforce that what the parent does and how a parent relates to their child makes a difference to how the child grows and learns.

The benefits of pediatric pathways to infants, families and pediatric care

Pediatric Pathways to Success enrolled 184 children under six months of age during the first eighteen months of the project: 40% are African-American, 25% are Haitian, 13% are Latino, 5% are Asian and the rest (17%) are African, Caucasian, Caribbean and Cape Verdean.

Infant health

Of the 184 children who were initially enrolled in Pediatric pathways, 156 are still actively involved in the program. Thirteen percent have transferred to other local health facilities. The drop-out rate after the first eighteen months is extremely low, only 2.2%, compared to approximately 45% for the entire pediatric well child practice at Boston City Hospital and 12% nationwide. Pathways offers a broad safety net that some new parents need to maintain their compliance with pediatric well child care visits. If a Pathways child does not show up for a scheduled appointment, the family advocate calls to find out if the parents need any help getting to the appointment. For some parents struggling with poverty, repeated visits for well child care may appear unnecessary and overly burdensome. For other parents, there is a language/cultural barrier to continuity of care. Often, a call from the family advocate, who can speak to the family in their primary language, helps them feel more comfortable with the health care system and helps them to understand why the baby needs to return for pediatric care even when she is not sick.

For some families, the ability to organize themselves and their children to get to the hospital by bus and subway requires extraordinary measures. The family advocate's goal is to help families attend to their children's health care needs as their first priority. Nine Pathways families, with help from their family advocate, chose to use more conveniently located neighborhood health facilities for their children. Finally, for families affected by substance abuse or domestic issues, personal encouragement from the program through phone contact, letters, cards and/or home visits from the family advocate can sometimes help a parent be more aware of the baby's health needs.

Eighty-eight percent of all Pediatric Pathways families are fully up-to-date in their immunizations, compared to only 45% of all Boston children who are fully immunized by age 2. None of the children have abnormally high lead levels, nor have any been referred to the Grow Clinic for failure-to-thrive. Because both lead poisoning and malnutrition in very young children can lead to developmental delay, reading problems, and behavioral disturbances, it is significant that Pathways children have been protected from these environmental risk factors which are often associated with poverty.

A chart review of a random sample of 50 BCH primary care patients under the age of 2 indicates 330 emergency room visits, with an average of 6.6 ER visits per patient. In contrast, a random sample of 120 Pathways children under eighteen months of age had only 177 emergency room visits, with 1.5 visits/patient. In the same chart review, 32% of BCH children under two had been hospitalized since birth (16 out of 50). Only two Pathways children were admitted to the hospital during the first eighteen months of the project. Given the national agenda to reduce health care costs, it is impressive that the use of the emergency room and hospitalizations were significantly reduced for Pathways families.

Family support

Almost every family who has been asked to participate in Pediatric Pathways has been willing to enroll in the program. Some proceed with caution based, in part, on their prior negative experiences with programs designed "to help." The following vignette is typical of the experiences of many families as they develop relationships with the Pathways team.

Ms. Dorcas was approached by a Family Advocate during her first two-week well child visit with the pediatric nurse practitioner. She was initially concerned about enrolling her premature daughter Sara in the program. She was especially cautious about the role of the Family Advocate. Was she a social worker from the hospital? Ms. Dorcas continued to express concern about the Family Advocate, but she agreed to participate. At the one-month visit, she talked about her older son, who wanted a job for the summer. She was delighted when Ann, the Family Advocate, called her with information about the Summer Youth Jobs Program. Two weeks later, Ms. Dorcas called Ann. Her welfare check had not arrived and she had no milk or diapers for the baby. She was crying and depressed. Ann arranged to meet Ms. Dorcas at the hospital to pick up extra diapers and formula. The successful resolution of that first crisis quickly brought a second call to Ann. Ms. Dorcas admitted that she was having marital difficulties and appeared open to seeing a marriage counselor. She told Ann, "Calling you, I felt like I had a friend to talk to." At the two-month visit, Ms. Dorcas invited Ann to the baby's christening. Ann declined the invitation, but sent a baby book from Pathways as a present.

Ms. Dorcas continued to bring Sara for her well child visits and the baby was growing well. At six months she performed within normal limits for her corrected age on the developmental screen and mother reported few problems with her care. Soon after that visit, she called the Family Advocate again. She told Ann that her older son had moved in with his aunt. In fact, the son had filed a complaint with child protection, stating that his mother was ignoring his needs in favor of the new baby. He felt neglected by his mother and in conflict with his stepfather, who was Sara's father. Baby Sara was a cheerful 7 month old, smiling at everyone and the delight of the household, while the fifteen-year-old son was struggling with normal adolescent issues and felt abandoned. Ann spoke with child protection on behalf of Ms. Dorcas and arranged for the son to see a counselor. She continued to support Ms. Dorcas' parenting of the baby.

At one year, the baby was observed by the early childhood specialist to have weak motor tone in her lower extremities and, in consultation with the primary care clinician, a referral was made for occupational therapy, which has continued through weekly home visits. Recently, Ms. Dorcas expressed interest in returning to work and was enthusiastic about enrolling in the Family Literacy Program at BCH. She is now

working weekly with a tutor to complete her GED while Sara stays with a volunteer child care provider in the BCH Family Library. Ann is helping Ms. Dorcas locate quality child care in the community so that she can begin to look for a job.

Many of the roles which the Family Advocate assumed with Ms. Dorcas were not directly related to the baby or her medical care. Yet the successful resolution of that first crisis involving the baby's immediate needs for food and clothing convinced Ms. Dorcas that the Family Advocate could be trusted with family business. Her willingness to discuss marital and family difficulties, her ability to follow through on difficult mental health referrals, and her desire to actively use the resources offered by the program speaks to the power of that first intervention based on the baby's needs. Ms. Dorcas brought her premature baby to the pediatric practice for health care; she now uses Pediatric Pathways for child development information, family support, and job training.

Effectiveness of pediatric practice

The pediatric primary care clinicians involved with Pathways have been uniformly enthusiastic in their response to the program. As one clinician says, "Nothing falls through the cracks anymore. I have more time to make relationships with families because I don't have to worry about all the needs of a family. If I spend time in the office listening to a mother's concerns about the domestic violence which the children witness in the home, I know that the family advocate will follow-up with all the things I haven't talked about—nutrition and development. Pathways is a safety net for our patients".

Discussions with parents about child safety, nutrition, and development are often put on hold in the face of an impending crisis. For some families, especially those involved in substance abuse or domestic violence, crises become a way of "organizing" their lives; the children get sick, transportation vouchers get lost or stolen, they are evicted. It is hard to focus on child development in the face of homelessness; however, the role of the Pathways team is to stay in close touch with the family, oversee the health and development of the child during the crisis, and to "be there" for the family during and after the crisis. The family advocate is often the provider who represents the pediatric practice for the family, ensuring the health and well being of the children. Riding out a crisis with a family reinforces the therapeutic relationship and strengthens the bond between the pediatric practice and the family. A Pathways clinician explained the alliance in this way: "It's not about just giving out a toy or a book; its about letting families know that we care about them."

The Pathways team members have learned quite a lot from the experience of working on a multidisciplinary team. Through joint well child visits with the family, pediatric primary care clinicians hear what the family advocates emphasize, how they respond to cultural issues, how they support a family's efforts or set limits on a family's behavior. The family advocates, in turn, learn how to talk with a family about medical conditions, substance abuse, or domestic violence and the effects on their children. Families learn, that their children's health is affected by adult behavior, and they experience a new type of therapeutic relationship with the health care system. Families learn which team member to call with their question or concern and gain confidence in their ability to access information and help for their children.

Conclusion

As a model of enhanced pediatric care, Pediatric Pathways uses the pediatric well child visit as a window of opportunity to address critical issues which impact on child growth and development. The key component to the success of Pathways is the relationship which the family develops with the primary care clinician and the family advocate. Child development information and family support can then be provided within the context of those two relationships. Pediatric Pathways focuses on three simple, yet key points. First, Pathways emphasizes to parents, providers and the community that the early childhood years from birth to three really matter. Using the *Heart Start* principles (1992), we have mobilized health, educational and community resources on behalf of very young children. Second, child health and development can best be promoted when families feel validated in their concerns about their caregiving responsibilities and supported in their desire to feel confident as parents, to feel like "good parents." Finally, Pathways has created a model of medical-educational collaboration which makes pediatric practice more effective in meeting the needs of young children and families by expanding the vision of pediatric care from one which focuses exclusively on health to one which provides child development information and family support within the context of the child's pediatric care.

References

Frank, D., Napoleone, M., Meyers, A., Roos, N., Peterson, K., et al. (1991). A heat or eat effect? Seasonal changes in weight for age in a pediatric emergency room. Paper given at the Annual Meeting of the American Public Health Association, Atlanta, GA.

Kaplan-Sanoff, M., & Rice, K. F. (1992). Woman and Infants Clinic: Lessons learned from working with addicted women in recovery and their children. *Zero to Three*, 13(3), 17-22.

National Commission on Children. (1991). *Beyond Rhetoric: A New American Agenda for Children and Families.*

Needlman, R., & Zuckerman, B. (1992). Literacy development: A primer for pediatricians.*Contemporary Pediatrics*, 9, 41-60.

ZERO TO THREE. (1992). *Heart Start: The emotional foundations of school readiness.* Arlington, VA: Author.

Zuckerman, B. & Parker, S. (1995). Preventive pediatrics- New models of providing needed health services. *Pediatrics*, 95 (5), 758-762.

The Soho Parenting Center:
A model for the integration of a parenting service into a pediatric practice

Lisa Spiegel, M.A., and **Jean Kunhardt,** M.A.
Soho Parenting Center, New York City

New parenthood is a dramatic life change. The intensity of feelings coupled with the often challenging nature of caring for a new baby can humble even the most confident and competent adults. During these early months, many parents become attached to and dependent upon their baby's pediatrician. After parents watch him or her give the first exam, confidently springing the baby's wiry legs and checking the tiny heartbeat, this doctor fast becomes a central and critical new figure in a family's life. The pediatric visits of early infancy, though frequent, are typically not frequent enough to satisfy the needs of new parents. As they become immersed in the wonder, excitement, fear, and confusion of their new responsibility, parents often experience new levels of neediness: the need for information, confirmation of their observations and instincts, and a receptive ear to hear their concerns and questions.

Drs. Marie Keith and Robert Coffey of The Soho Pediatric Group in New York City recognize and normalize this developmental crisis in family life by including a parenting center in their pediatric practice. *The Soho Parenting Center,* co-directed and founded by Jean Kunhardt, M.A., and Lisa Spiegel, M.A., offers a range of parenting and psychological services to families at the Soho Pediatric Group. They have taken this service from its infancy to a popular parenting center that is fully integrated into this large pediatric practice. The integration of *The Soho Parenting Center* into a primary care setting is the realization of a dream that Spiegel and Kunhardt began to formulate eight years ago. This article traces the Center's development and uses case material to illustrate the importance of combining pediatric medicine with psychological services. This progressive approach more fully supports the normal developmental process of family life and helps to effectively track and treat families in need of therapeutic intervention.

A "tour" through the *Soho Pediatric Group/Soho Parenting Center* helps to give a sense of the on-site nature of these joined services. One enters a large waiting room filled with toys and a wealth of parenting magazines and resources. From here, one door leads to *The Soho Parenting Center's* main room. The walls are covered with children's art and photo collages recording eight years of mother-infant groups. On any weekday morning one can watch a group of toddlers playing with their teachers at the water table, or hearing a story, or dancing with scarves while their mothers sit in a circle of chairs across the room. The women are engaged in discussion about some aspect of parenthood, led by one of the counselors. The topic may be limit setting, or changes in their marriages, or the mechanics and emotional impact of toilet training. The discussions are intimate and intense and often peppered with laughter and tears. There is an easy workable flow between the children's play area and the circle of mothers.

Next comes a smaller consultation room: here a woman is engaged in individual psychotherapy. Although her baby was gaining adequate weight, she was experiencing pervasive anxiety about her ability to nurture her. Her baby's pediatrician recommended a consultation with one of the parenting specialists. Through exploration of her anxiety she soon realized that her presen-day worries had their roots in her own childhood. Once treatment was underway she expressed great relief at the easing of tension with her baby.

Down another corridor there are five medical exam rooms, a nurses' station, a hearing and vision room, a conference area, and the doctors' office area. Among the bustling activity there is a relaxed and familial quality between the medical staff and the families they treat.

At the end of this hall of examining rooms is one last consultation room. It is big enough for a play session or a family consultation. Here another counselor is meeting with a couple embroiled in conflict over their baby's erratic sleep patterns. The mother cannot bear to let the baby cry, but the father is demanding that they regulate the baby's sleep. Their disagreement has uncovered some longstanding marital discord that needs some immediate attention before the counselor can help them come up with a workable sleep plan.

This present-day scenario illustrates how two different disciplines can work together to provide comprehensive care for families with young children. Spiegel

---

Jean Kunhardt and Lisa Spiegel are co-authors of the forthcoming book, *Circle of Mothers,* to be published by Avon Press in Spring, 1996. The book chronicles one of Soho Parenting Center's eight-week mother-infant groups. It delves into important issues of infant development as well as mothers' emotional responses to becoming a parent.

and Kunhardt's early experiences on staff at Bellevue Hospital in New York City helped to provide the foundation for the idea behind this parenting center. Lisa Spiegel has a Masters degree in developmental psychology from Columbia University. She began her experience at Bellevue Hospital in 1982 as a children's counselor in the Adolescent Mothers Group in the Department of Child and Adolescent Psychiatry. In 1985 Spiegel also began working in the Child Life Department in Outpatient Pediatrics, running a developmental screening program in the hallway of the clinic. This play program was set up on mats with toys for children ages birth through three years. Their mothers sat in chairs around the perimeter of these mats while waiting for their child's pediatric appointments. The aim of this program was to provide information and guidance for parents while informally assessing their child's development. The pediatrician was then easily contacted if there was some concern about the child or parent's functioning.

At the same time, Jean Kunhardt was running a similar program in the playroom of the clinic for children ages three to seven. Kunhardt received her Master's degree in Special Education from Bank Street College. She had been a second and third grade teacher at a private elementary school and taught emotionally disturbed and developmentally delayed children. With a solid foundation in both normal and abnormal child development she joined Bellevue's Child Life team in 1984. There, along with the play screening program, she coordinated the family counseling component of the sex abuse clinic.

Kunhardt and Spiegel also worked in the Adolescent Parenting Program, which combined a parenting group with pediatric and gynecological care. They provided play therapy and counseling for families struggling with the debilitating effects of AIDS, homelessness, abuse and neglect. They received clinical supervision and training from experts in the fields of psychiatry, clinical psychology and social work. This training served as a model for the collaboration between psychological and medical services.

In 1987, both Kunhardt and Spiegel left Bellevue, began their own families and personally experienced the unmatchable and life-transforming nature of becoming a parent. Although their professional experiences and graduate work laid the foundation for their ideas about parenting and psychological development, it was really more their own experience of being mothers together that inspired the creation of ParenTalk, their early parenting program.

With babies in tow, and masking tape on their stroller handles they posted handmade flyers on Broadway advertising their first Mother-Infant Group. Eight mothers and their babies gathered weekly for two months in Spiegel's living room to discuss their baby's development as well as their own emotional response to becoming mothers. The women needed to talk about the dramatic changes in their lives, their ideas about work, about marriage, sexuality and friendship as well as the intricate details of their baby's sleep, eating and need for comfort and play.

Having heard through a mutual colleague at Bellevue that Drs. Robert Coffey and Marie Keith were interested in providing parenting services to their patients, Spiegel and Kunhardt approached them with the idea of working together. Dr. Keith had also trained at Bellevue Hospital and both doctors recognized the potential benefit to integrating medical and psychosocial services. With a mutual long-range vision in mind, the first Mother-Infant Groups were begun in a space adjacent to the doctors" medical offices.

Keith and Coffey encouraged mothers to join Mother-Infant Groups and also began referring families for individual consultation when behavioral and parenting concerns required more in-depth attention. Because the therapists were on-site these gentle referrals became a more effective method of intervening when a family was experiencing difficulty.

Parents responded with enthusiasm to the doctors for their referral to ParenTalk. Dr. Keith remembers:
Early in the course of our collaboration, when our patients chose to join Mother-Infant Groups, it became obvious that the benefits to the mothers were significant. They developed a special kind of self-confidence about providing loving care as well as age appropriate limits. Not only did our patients derive enormous assistance from this program, but we were also aided. We had a marked decrease in telephone consults and time spent with patients over issues that Kunhardt and Spiegel could handle with expertise.

The service quickly grew, adding a Mother-Toddler program, groups for second-time mothers, evening groups for working parents, and an ongoing therapy group for mothers. The service also offered individual parent counseling, play therapy, long-term psychotherapy and marital counseling. In 1992, another therapist, Barbara Melson, M.S. ADTR, joined the practice. Over time Spiegel, Kunhardt, and Melson have become a trusted resource that families turn to for developmental guidance, support and therapeutic intervention.

The pediatricians report that parents are more likely to request and follow through when that therapeutic support comes from someone the parent has had contact with since the birth of the baby.

A family who comes for assistance with their five-month-old's sleep problem comes for help when their child resists toilet training at age three. A couple who has been in a New Parents Group calls one year later when they are experiencing marital conflict over childrearing issues. A one time member of a Mother-Infant Group schedules a consultation three years later, worried that her child is not developing language appropriately. Dr. Coffey comments:

The availability of individual counseling around specific parenting problems has allowed us to provide early interven-

tion for families before their problems become crises. Since it is provided on-site it does not carry the stigma that some patients may attach to "psychological" or "emotional" family problems. Providing these services is an open acknowledgment that all families will struggle at times and that input from a trusted professional can enrich and empower parents.

In 1993, Drs. Coffey and Keith along with Kunhardt and Spiegel agreed to more fully integrate their two services. Each family using the Soho Pediatric Group would now be entitled to a parent counseling component during their child's first year of care. An eight-week Mother-Infant Group, a New Parents Group, or three individual parent counseling sessions were now to be an integral part of regular pediatric care. In the same year, The Soho Pediatric Group and ParenTalk moved to a new Soho loft which could house both practices. To reflect the expansion of services as well as the closer affiliation with the doctors, ParenTalk was renamed *The Soho Parenting Center.*

The following two case reports illustrate the power and effectiveness of this progressive approach to pediatric care.

Suzannah and her husband Jeff, brought their son Ezra, to the Soho Pediatric Group for his medical care and so were entitled to a choice of parent counseling options. The R's opted for the individual counseling sessions and came together for a consultation when Ezra was 3 months old. Though they stated to Spiegel that they wanted some guidance about Ezra's eating, it became clear in the first few minutes of the meeting that Suzannah was agitated and worried about more than feeding her baby.

While Jeff held Ezra and rocked him, Suzannah began to confide that she was having a difficult adjustment to motherhood. Ezra was often cranky and demanding and she felt angry at him much of the time. As Spiegel asked questions to round out the picture, Suzannah revealed a well of self-doubt about her abilities as a mother. With her husband's urging and support she told about her own mother's history of mental illness and her worry that she too was "crazy" and would damage Ezra. She experienced persistent worry that Ezra would "not make it," " be a loser." A broader family history also uncovered an uncle who suffered from manic-depressive disorder and who never was able to leave home and establish a life on his own.

Suzannah emerged from her difficult upbringing a sensitive, yet highly vulnerable person who periodically suffered from anxiety and depression. She had gone into mothering feeling that nurturing a baby would somehow free her from this past and instead found herself inextricably bound to it. Jeff was able to inject some very positive praises of his wife's ability to care for and nurture Ezra and attest to her connection to him. It seemed that Suzannah's negative self image and worries about Ezra felt overwhelming but in fact did not totally keep her from being available to her baby.

Spiegel explored further and found that Suzannah had been in treatment for several years in her mid 20's but had discontinued therapy when she met and married Jeff. Although she is an insightful and introspective person, she expressed strong resistance to any further individual psychotherapy at this time. The idea of continuing to work in this format with her husband and baby seemed less threatening to her. Spiegel offered to continue seeing the family for some counseling sessions with the hope of untangling some of these deep and complicated issues.

From Ezra's third to sixth month the family came to weekly counseling sessions and explored both the psychological issues raised in the first meeting, as well as Ezra's eating, sleep and growing attachment to both parents. Jeff felt relieved that Suzannah was less worried, less angry and more confident in her mothering. Suzannah too, seemed to be falling in love with her baby in a new way, but still seemed unresolved and sad about her own childhood issues. The family as a whole was doing well and when Ezra turned six months the R's decided to end their short-term counseling, knowing that they could return at any time.

When Ezra turned a year and issues of autonomy and limit setting rose to the fore, Suzannah called again and requested membership in The Mother-Toddler Program led by Kunhardt. She hoped to provide Ezra with a peer group as well as a regular forum for her to discuss parenting issues. What became increasingly clear as the group progressed was the discrepancy between Suzannah's internal sense of herself as a mother and how she in fact related with Ezra while at the group. Throughout the sessions Suzannah showed sensitivity towards and enjoyment of her son, who is an engaging boy, full of life and humor. Within the context of the group, she could take pride in his obvious intelligence and sociability.

There is a startling contrast, however, between this picture of an involved and caring mother and Suzannah's description of their interactions at home. There, she reports feeling unduly harsh and verbally punitive with Ezra. She describes herself as tense and obsessive in her need for order and cleanliness in her home and finds herself often resentful of Ezra's age-appropriate exploratory messiness. There is a pressured feel to the way she approaches her role as mother — a lack of relaxed, spontaneous or mutually satisfying play. Despite her obvious devotion to him, Suzannah is sadly blocked from fully enjoying the experience of mothering.

There are several areas in which the group has been immediately helpful to Suzannah. Seeing how the other mothers balance their own needs with those of their children has been one of them. She complained of feeling overwhelmed and in need of time away from Ezra. She and Jeff had the financial resources to get additional babysitting help and Jeff encouraged this yet; Suzannah took very little time away from her mothering responsibilities. Perhaps fearing that Ezra would experience the same deprivation that she did as a child, Suzannah ignored her own needs for a break from him. Suzannah's reaction to her own unresolved history was making her blind to her own needs and hence actualizing what she was trying to avoid—an emotional unavailability to Ezra. The other group members have been extremely helpful to Suzannah in this regard. Their attempts to understand why she is so reticent to leave her son have enabled her to accept their encourage-

© Michael Hoebler

ment to get more childcare. This in turn has helped her to feel more positively towards Ezra.

Limit-setting is another difficult arena for Suzannah. She does not trust her own ability to respond appropriately when she is angered by Ezra's behavior. She often lets his normal testing and somewhat provocative behavior go unchecked past the point where he can control himself. Without the limits he needs, Ezra keeps pushing to see what will happen. After prolonged periods of noncommittal attempts at verbal reasoning with him Suzannah becomes exasperated, and this is the point at which she reports"losing her cool." It has been helpful to analyze with Suzannah how her reticence to step in with clear boundaries early on can actually escalate and exacerbate the whole incident. Through discussion, modeling and practice Suzannah has become more comfortable in her role as disciplinarian.

The most helpful aspect of this group for Suzannah has been the opportunity to share with others that part of herself which she feels most vulnerable about. The other members of the group have given her a consistent, realistic view of Ezra that helps to counter her self-acknowledged unrealistic worry that something is wrong with him. Despite the benefits of this group for Suzannah, she continued to show evidence of extreme fragility. The slightest innuendo of criticism from another mother in the group or out in the world would send her into periods of anger and eventual self-hatred. During such a period, Suzannah and Kunhardt spoke and agreed that it would be helpful to meet individually. With sadness but new understanding, Suzannah acknowledged that her anxiety was not particular to any one stage of Ezra's development but rather was something inside of her and was seriously limiting her capacity to enjoy her son. Although still frightened, she was now ready to accept a referral for therapy. A decision was made to refer her to an analytically oriented psychiatrist who also specialized in psychopharmacology. This would allow for a comprehensive evaluation and the possibility of antidepressant medication if needed. Currently she continues in the toddler group and has begun her treatment.

It was clear from the moment Suzannah and her family entered their first consultation that becoming a mother was reigniting old and painful issues for her. The conflict and damaging effects of growing up in a family with a mother suffering from mental illness, came up with force once she was a mother herself.

The range of clinical interventions that are possible at The Soho Parenting Center allowed a gentle pathway for Suzannah to receive support and guidance. Going at her own pace, giving her what she was ready for and accepting her need to step in and out of the therapeutic process were all necessary prerequisites to gaining Suzannah's trust and her eventual referral for therapy.

BEST COPY AVAILABLE

Jesse, a blond-haired, blue-eyed fifteen-month-old, was a patient at the Soho pediatric group since his birth in 1989. His mother Emily was a sensitive and reserved woman, always very attentive to Jesse's care and growth. At his fifteen month check-up, Emily mentioned a desire for Jesse to socialize with other children his age. His pediatrician, Dr. Robert Coffey, suggested that she and Jesse join the Mother-Toddler Program that ParenTalk offered at the practice. Jesse would be able to play with other children his age in the play program, and Emily could meet with other mothers and get developmental information from the parent counselor. Emily and Jesse did indeed join the Mother-Toddler Program. This would begin a long and essential therapeutic experience for this family.

Jesse's entry into the toddler program was difficult. He seemed fragile and somewhat lost in this exuberant group of girls and boys who ranged in age from 12 to 21 months. He had no expressive language, made little contact with toddler teachers, and stayed close by his mother during most of the beginning weeks in the group. There was a ritualized quality to his movements, his eye contact was minimal, and there was a faraway feeling to his demeanor. There was immediate concern about Jesse's development.

The discussion group and play program take place in one room so that children are free to move back and forth between their mothers and the toddler teachers. For Jesse and Emily, even this mild separation was problematic. Both were unable to fully engage in the program and seemed agitated. In this particular program Kunhardt led the discussion and Spiegel coordinated the toddler program. Spiegel became Jesse's designated "special person," a technique used in the Bellevue Nursery to help children who are having difficulty separating. She concentrated on building a connection with Jesse in a non-intrusive manner. This seemed to help Jesse move into the play program for short amounts of time.

After the first eight-week group ended, Emily decided to continue in the next session. It became increasingly clear that Jesse's separation difficulties were not abating, and his behavior began to appear more atypical. Jesse would whine and pull at his mother's arm to leave, making it impossible for her to participate in the discussion. Emily appeared confused, upset, and very defensive about Jesse's behavior. When other children initiated contact with him, even in a friendly manner, he became more withdrawn. Emily was unable to see and accept her child's obvious vulnerabilities and instead focused on Jesse being the brunt of aggressive play with the toddlers. She wanted to leave the group.

Kunhardt scheduled an individual session with Emily to discuss the situation and explore other possibilities of helping the family at this time. Emily declined the offer of individual sessions to discuss Jesse's behavior or her own concerns at this time and decided to leave the group. Dr. Coffey was kept abreast of these details. It was decided that he would track Jesse's development through his pediatric visits and make another intervention when the parents seemed more open.

This opportunity arose when Jesse turned three. He had begun nursery school and had a very difficult time separating from his mother. He was unable to make contact with other children or connect to his teachers and was withdrawing under a table in the classroom. The teachers suggested that Jesse was having emotional problems and seemed anxious to have him leave the school.

Emily contacted Kunhardt for some guidance at this time. She expressed worry that Jesse was in the wrong school program and felt that the teachers and staff there were insensitive to his needs. Emily and her husband were both very concerned that Jesse had become withdrawn and were worried that the nursery program had damaged him in some way. Kunhardt met with Emily and spoke to Jesse's previous day care teacher and his current teacher. It was clear that Jesse's ability to engage in social contact with persons other than his parents was severely limited and that his language was significantly delayed. The other professionals who had contact with the family felt that the parents were extremely defended against the possibility that Jesse's development was unusual.

Kunhardt, Spiegel and Dr. Coffey conferred and agreed that this seemed to be the time to intervene in a more forceful way while being sensitive to the defenses of the parents. Kunhardt informed Emily that Spiegel worked as a therapist with children with language delays. The fact that Spiegel had known Jesse as a toddler seemed to be a comfort to Emily. Spiegel suggested that she and Jesse come for a play/observation to determine what would be most helpful.

Jesse's behavior indicated that he had a pervasive developmental delay. He had very little language, used his mother's hands and body to manipulate objects for him, made little eye contact, and exhibited repetitive body motions. He did, though, seem comfortable in the room and was interested in playing with toys with his mother. Spiegel suggested that these mother-child play sessions would be a good way to help stimulate Jesse's language. Having Emily there would insure Jesse's comfort and not press him to separate at a time when it felt too difficult for him.

Parents usually have an easier time committing to the treatment of a language problem than an emotional one. It sometimes takes months or even years for parents to consciously recognize the severity of a disorder of this magnitude. In order to address the emotional nature of Jesse's difficulties without overwhelming the family, Spiegel focused on the parents' worry about Jesse's withdrawal since the school experience and suggested that play therapy could help him to work through some of these feelings.

At this time, Spiegel was working with other children who exhibited autistic-like features in a tripartite treatment plan: child, therapist and parent, under the supervision of Dr. Anni Bergman. Spiegel recommended that Emily and her husband Daniel have a consultation with Dr. Bergman to reassure the father, who was dubious about any intervention. Dr. Bergman supported Emily and Daniel's decision to remove Jesse from the nursery school and backed up the recommendation that he and his mother attend twice-weekly play/language sessions with Spiegel.

Jesse and his mother attended the mother-child play therapy sessions for one year. Both parents attended monthly parent counseling sessions with Spiegel as well. Through play, interpretation, and a building of the communication between Emily and Jesse, dramatic changes took place in the first year of treat-

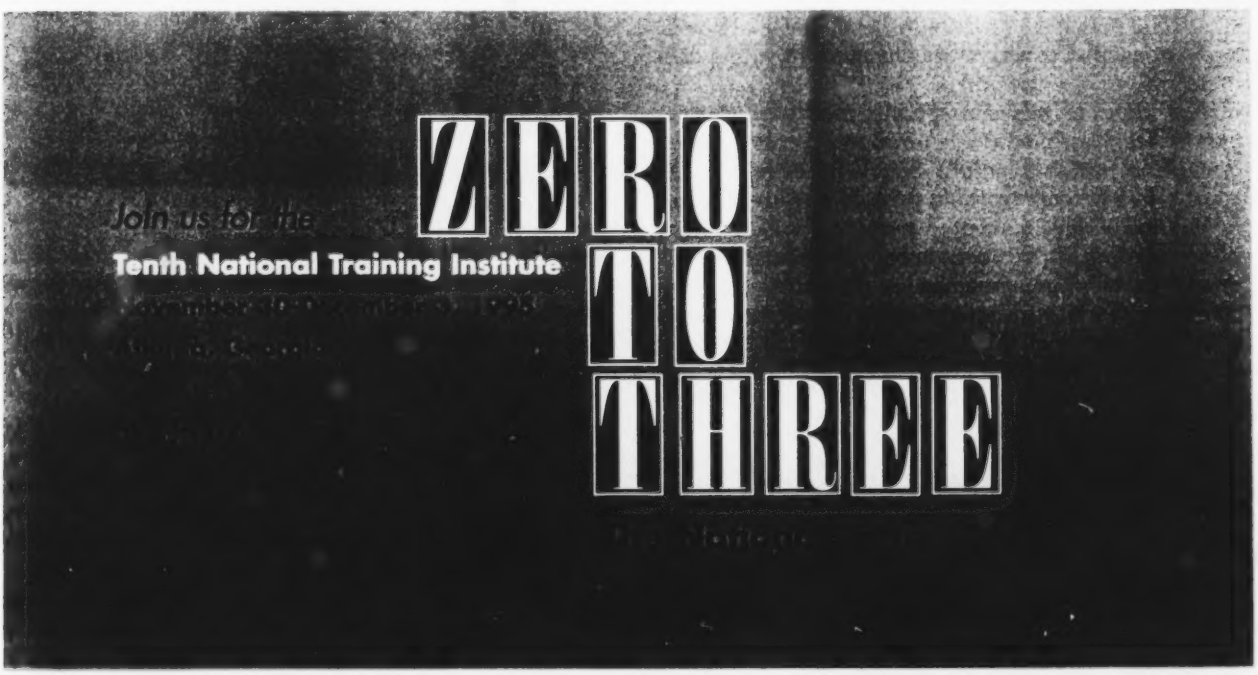
ment. Jesse's language development exploded. Though somewhat idiosyncratic in content and articulation, his ability to express himself in words was largely age-appropriate by four and one-half years. He began to form an attachment relationship to Spiegel, engaging her in play, making eye contact, developing games and rituals together. In the nest of these two important women, mother and therapist, Jesse began to emerge into the world of relationships.

When he was four, Jesse was accepted on probation at another private nursery program in a three-year-old classroom. Spiegel maintained close contact with the school psychologist and teachers. She visited Jesse at school and closely followed his progress there. He remained more of an observer than participant in this first year but was gradually developing connections to other children and teachers.

Though very much encouraged by Jesse's progress in therapy, Emily began to let in the enormity of the difference between Jesse and other children. She began a conscious mourning process over the now-recognized loss of her "normal" little boy. It was at this time that Spiegel encouraged Emily to get in to treatment of her own and have Jesse begin individual play therapy. As Emily let down her defenses, Jesse's father's defenses became stronger. Although Daniel did not stop the play therapy, he was somewhat antagonistic to the process and wedded to the denial of hs son's developmental difficulties. He decided to have Jesse evaluated by another child psychologist in an effort to prove to his wife that there was in fact nothing seriously wrong with Jesse's emotional development. This move, meant to sabotage Jesse's treatment, ultimately strengthened it. The evaluation confirmed a diagnosis of pervasive developmental delay. The psychologist strongly stressed the importance of Jesse's therapy and underscored its integral role in Jesse's progress. Daniel was able to process this information and not only joined the team in spirit but began to call Spiegel himself between parent appointments to ask for advice on issues between himself and his son.

Currently Jesse is at the end of his second year of treatment. He has moved from repetitive and idiosyncratic play with toys to sessions filled with discussion of his feelings. He speaks and plays about school, friends, his parents, and is able to express anger and love to his therapist. He has become an important figure in his classroom. He initiates and participates in almost all activities with teachers and peers and uses his very precocious reading skills to hold a place of high esteem in his classroom. He is invited on playdates and to birthday parties. Jesse remains a highly sensitive boy whose development continues to need support and whose complicated and quirky ways of communicating need interpretation. Despite this vulnerability, he has grown into a loving, responsive child who is a player in his world.

The interaction between Jesse's pediatric care and the readily available parenting and psychological services made it possible to offer a comprehensive approach to Jesse's medical and socioemotional needs. For parents to come to terms with the therapeutic needs of their child is a sensitive and slow process. The services available, from parenting groups to play therapy offer ways in which to detect and treat vulnerable families in a timely and sensitive manner. A pediatric and parenting center like the Soho Parenting Center creates a community of caring around a family.



BEST COPY AVAILABLE

The Touchpoints Model:
Building Supportive Alliances between Parents and Professionals

Ann C. Stadtler, M.S.N., C.P.N.P.;
Maureen A. O'Brien, Ph.D., and
John Hornstein, M.Ed.

The Touchpoints Project, Boston, Massachusetts

At the Touchpoints Project, we have created a training model for practitioners that emphasizes the building of supportive alliances between parents and professionals. We view the model as a way to meet the needs of both families with young children and practitioners who work within an increasingly demanding health care system. A key element of the Touchpoints model is anticipatory guidance, through which practitioners reach out and engage parents around important, predictable phases of their baby's development. The Project grew from Dr. T. Berry Brazelton's book, *Touchpoints* (1992), and from more than 20 years of training and research with parents and practitioners carried on at the Child Development Unit, Children's Hospital, Boston.

What makes the Touchpoints approach a valuable tool for practitioners? We feel that Touchpoints' key strengths are its use of the child's behavior as the language of communication with parents and its focus on developing practitioner-parent relationships. The model is grounded within a conceptual framework which helps both parent and practitioner recognize, understand, and anticipate predictable developmental bursts, regressions, and pauses in the behavior of young children.

According to this conceptual framework, "touchpoints" are those predictable times and events in development at which a child's behavior seems "to fall apart." Touchpoints typically precede a spurt in a particular line of development — walking, for example, or understanding object permanence. Although touchpoints are often accompanied by frustration and self-doubt on the part of parents, practitioners concerned with the health and well-being of young children and families view touchpoints as occasions of change for the child, the parent, and the family as a whole. As such, touchpoints offer health, education, and social service professionals an opportunity to make a positive difference in the lives of young children and families. Through understanding and anticipating each of the touchpoints together, parents and practitioners can collaboratively plan strategies to reduce or prevent the negative consequences of the behavioral disorganization that accompanies a developmental spurt. The practitioner joins the parents and supports them in working through the disorganization by helping them to see it as a positive accomplishment for the child. The trusting relationship between practitioner and parent that develops and deepens over time fosters the parent's self-esteem and becomes a true therapeutic alliance on behalf of the child.

Robert Maust

The parents' passion for their child constitutes the core of the Touchpoints relationship. Practitioners join with the parents around their child, and it is through the child, and parents' feelings for their child, that change in parents occurs. Practitioners understand that powerful emotions are the driving force in parenting. Parents may feel ambivalence about becoming a parent in the first place, fierce competition with the other parent for a child's affection, or distress at the prospect of a child's

emerging independence. The practitioner's job is to understand and work with emotional forces, to support parents and develop competent parenting.

The Touchpoints model provides the practitioner with a framework to guide their interactions with families. It:

- stresses that meaningful relationships **develop over time** and that each touchpoint deepens the relationship;
- acknowledges that forming **relationships** is critical if we are to appreciate the significance of cultural, religious, and societal variables for families;
- invites practitioners to **reflect** on their role in the system of care around the child and family;
- encourages practitioners to focus on **strengths**, rather than deficits, in individuals and families;
- provides insight into the emotional experience of the **developing parent;**
- departs from traditional medical and social service provision in its **multidisciplinary** approach;
- strives to create a sense of **community** at each of the touchpoints, by establishing **peer groups** of expectant parents during pregnancy and bringing them together as they experience each touchpoint in their children's early years.

Listening to parents' voices

As part of the Touchpoints Project, we convened groups of parents with children at particular touchpoint ages — two weeks, seven weeks, four months, seven months, nine months, and 12 months. Our goal was to listen, rather than to provide answers — to hear the issues that concerned parents, which they would be likely to bring to professionals. The Touchpoints framework helped us to anticipate most of the issues parents raised; unanticipated concerns of parents helped us to refine the model.

Parents in all of the groups talked about their roles — being a mother, a father, or a single parent trying to play both roles — and their experiences of these roles. One mother, for example, said, "I feel like I have to do everything (for my baby). Even if she is in the swing or playpen or the crib, she needs me." Parents talked about balancing the demands of work and home, trying to make up for not "being there," and finding time for themselves and their partners. They talked about feeding, sleeping, safety, and developmental issues. They talked about their supports and their lack of supports. They offered suggestions and shared stories of success and failures. Each group had a unique atmosphere.

The seven-month Touchpoint Group

The group of parents with seven-month-olds illustrates particularly well how common issues bring parents together in a Touchpoints Group. Child development professionals know that the seven-month-old is dealing with issues of permanence and mastery. Babies are concerned about separation from their parents and want to practice their new motor skills whenever they have the opportunity. These issues, in turn, affect feeding, sleeping, communicating, and safety. At the seven-month well child visit, health care providers typically discuss, among other behaviors, the child's difficulty with going to sleep and waking again at night and his desire to feed himself. Yet practitioners often feel unable to address other important parental concerns in the limited time they have available.

For our Touchpoints Groups, we met with two sets of parents with children seven months old—one suburban group and one from the inner city. At first glance, the parents appeared dramatically different. Parents in the suburban group represented a wide range of age and marital status and were concerned about fertility, pregnancy, birth, economic, and occupational issues. The inner-city group of parents, all of whom received their health care at a neighborhood health center, reflected other kinds of diversity. This group included incarcerated mothers, homeless families, people in recovery from substance abuse, women caring for foster children, and mothers with other children in foster care. The "language" common to both groups was their seven-month-old children.

Parents in both groups talked about feeding, sleeping, safety, playing with their babies, establishing balance in their lives, and relating to significant others. They talked about feeling frustrated when they couldn't understand the meaning of their child's fussing. They didn't know if the baby was sick, teething, or frustrated. Parents talked about how they managed their daily lives in their various circumstances. They shared their feelings of guilt when they thought their child was "acting spoiled" and then discovered that she was really sick. They talked about trying to encourage independence and avoid spoiling their child. This meant different things to each parent: for the incarcerated mothers and the parents of a premature infant, for example, "independence" meant that the baby was strong and capable of surviving. Parents talked about when you do something about fussing, and when you don't. They spoke of how their babies manipulate them—"She knows that if she cries, I'll come to her."

A discussion of crying in one of the groups led to the following dialogue, in which Ann took the role of group facilitator, sometimes letting the group steer the discussion and sometimes taking advantage of opportunities to bring discussion to another level.

Ann: . . . it sounds now like there's a lot of energy that goes into figuring out what your babies need, whereas in the beginning you were guessing. Then they couldn't tell you as much, but it sounds like . . .

Richard: They're communicating better now.

Richard finishes Ann's sentence. Both the process of infant development at seven months and the parallel changes in parents' perceptions of their infants are affirmed. But for another member of the group, this exchange raises one of the challenges of the seven-month touchpoint and of any discus-

sion among a group of parents—that is, obvious differences among children in the rate of development. These differences become more apparent as motor skills emerge.

Tara: My son is a little behind; he just started sitting up. He rolled over once. He's seven months old. I have friends where their kids are crawling. What's the matter with my kid?

Colleen: Sometimes I read books, and the books say by this age they should be doing this. I look at my daughter, and I say, "Crawl! Crawl!" Or, "Sit up." And you kind of feel bad when you see other people. You feel awkward, and you're like, "How come my daughter is not doing that?"

Tara: I'm not looking for him to crawl. People are like, "Don't wish for it." But you look at how fast other kids are doing it. The doctor says, "He'll do it when he does it." He's finally sitting up. That's encouraging, especially where he hasn't done those things. It gets frustrating sometimes. It's more work, because they're not able to crawl to what they want and roll over to what they want. Sometimes that's more work. I'm lucky — my son sleeps a wicked lot, and he's always been a sleeper. But when he's awake and just sitting there, he's like, "Okay, come entertain me. Come play with me."

Tara and Colleen are mirroring each other's fears. They are together with this in the face of "other people," including their health care provider. They are giving each other permission to express their feelings. Tara also ties perceived lack of developmental progress in her son to the frustration she and her baby both feel when he can't move the way he would like.

Rather than making a comment about development at this point, Ann chooses to let other members of the group join in the emotions surrounding this touchpoint. By refraining from intervening actively or offering "answers," Ann does not try to diminish the parents' fears. Rather, she lets the parents legitimize and normalize these real concerns. The developmental information then comes from the group itself.

Ann: Would anybody else want to comment on what was said? At this point, people are telling you everything is fine, but it's still frustrating if you see other children doing things that your children aren't doing.

Mandy: I came to grips with that. My daughter rolled over only once. I don't think she's even going to crawl.

Tara: My son is going to go from laying down to walking.

Mandy: She's just not going to do it.

Tara: He wants to see what's going on in the room, and he'll sit there in a chair or whatever, and he'll stand up, and he wants to check things out. But it's so funny.

Mandy: My daughter doesn't have teeth yet. There are other kids who have three teeth.

Tara: Mine has four. So I say, "When yours crawls over to mine, he's going to bite her." I have a girlfriend — she was ripped — my son had two teeth, and she's like, "Why doesn't mine have any teeth?"

Nancy: Every day you look for a tooth. She doesn't roll — she has a few times — but she's just getting ready to crawl. She sits up, and she's been doing that for a long time. But the teeth — I look for them, and I don't think they're ever going to come.

Colleen: My nephew is a year old this Sunday, and he just cut his first tooth two weeks ago. And my daughter is cutting her second one now.

Richard: They all go at their own pace, don't the...

Rather than Ann needing to summarize the discussion, Richard made the leap to one of the main points, which is that the parents have just described developmental differences that fall within the realm of normal child behavior. Throughout the discussion, Ann's strategy was to listen for behaviors consistent with the touchpoint and to monitor the developmental level of the babies, with an eye to any necessary follow-up. As these parents share new developments, frustrations, and successes, they hold mirrors up to each other. Through this sharing of common issues in the group, parents grow in their understanding of their child and in their confidence in their ability to parent their child.

Incorporating Touchpoints Groups into the health care system

Our current health care system demands that practitioners meet the needs of families in a timely, cost-effective manner. Many practitioners feel that it is nearly impossible to spend the time necessary to make alliances with parents while still providing them with the immediate care they need and that we want to provide.

In a typical well-child visit, hurried practitioners often resort to a more comfortable, "closed" approach to parents, in which they give advice but do not "open" areas for discussion which may demand more time than is available. At the seven-month visit, for example, a practitioner may give advice about self-feeding rather than exploring parents' feelings about this issue or asking about the family's overall well-being. The limits of this approach are often apparent by the time of the next visit. How often have we heard a practitioner lament, "If that mother would just listen to what I say and follow through, then she wouldn't have these problems with behavior!"

Time constraints keep parents from raising issues at their children's well-child visits — "I never ask my pediatrician these questions because he is too busy." Rather than turning to their health care providers, some parents rely exclusively on informal support networks for advice. One parent said, "If I have a question, I call my friend who has a child three months older, and she tells me what to expect." Other parents feel isolated in their parental role, and feel others cannot empathize with their situation. Clearly, in a hurried health care sys-

tem, both practitioners and parents can feel unheard and frustrated.

Touchpoints Groups offer both health care professionals and parents the time they need and a way to use available resources effectively. If children are seen for well-child care at regular times and these visits are reinforced by Touchpoints Groups, practitioners and parents can have rich individual and group encounters which do not leave them frustrated for lack of time. In this model, parents are active group participants, not an audience assembled to listen to professional advice. Building relationships with one another is a primary goal of the group. Through their children, parents connect to one another and share what it is like to be the parent of a developing child. Since Touchpoints Groups will occur at points at which we generally see a spurt in the child's development (and all of the disorganization which accompanies it), both individual and group encounters offer support arenas in which practitioners and parents can predict and problem-solve together.

Facilitating Touchpoints Groups

Facilitating a Touchpoint Group involves a combination of skills. The parents' own agenda must be able to surface. The process demands flexibility; the facilitator must know when to be more directive with the group, and when to let the group steer the direction of discussion. The facilitator must also be able to engage a "difficult" parent. In the seven-month Touchpoint Group meeting described above, for example, one of the fathers spent the first half of the session mumbling under his breath, not contributing to the group discussion. As the facilitator, Ann realized that she did not have a sense of the source of his frustration. Not wanting him to feel uncomfortable, she did not approach this father directly. Fortunately, however, before the session Ann had asked parents to write down issues that were concerning them at this time. During the break, she looked at the papers and saw that someone had written "DOCTORS" in capital letters. Knowing that someone in the group had strong feelings about the medical care they were receiving — and hoping that this someone might be John, the disgruntled father — Ann opened the second half of the group session this way:

Ann: One of the things that someone wrote down before the session was that one of their biggest frustrations is doctors. What has your pediatric experience been like so far?

John: Terrible. They talk to you like you're stupid. They give you a lot of lip service. You tell them a concern you have for your child. Because they say a certain thing, that's it. They don't believe the parent. They believe they know everything, and the parent knows nothing.

Mandy: I really like my pediatrician.

Debra: I can really understand were John is coming from. I feel you just get a little pat on the back, and they say, "Just try again." But a parent knows the baby.

Colleen (to John): Did you already switch doctors?

Mary (John's wife): We're looking for what's causing hives in our baby, and we're not getting any answers. That's very frustrating — when the baby is screaming, you know something is wrong. It's not in our heads.

Patrick: I know what you're saying.

Colleen: You can tell you're really frustrated with it.

At this point, John joined the group and felt supported by the other parents who affirmed his feelings of not being heard by his health care provider. As the discussion continued, the group helped John consider how to comfortably enter the system and gain control over his child's care. Before this discussion, Ann felt that John was transferring his negative feelings about his pediatric providers to her, and this had prevented him from engaging actively in the group. The group support freed John to focus on his child's behavior and the feelings these behaviors elicited in him. Following this discussion, however, John became a very active participant. At the close of the session, he said, "This was a great night. I'm so glad we came."

The Touchpoints model and the power of prediction

The Touchpoints model moves beyond discussion of what parents currently feel and understand about themselves and their child's development to look to the future. Together, the parent and practitioner anticipate the next developmental burst and how it will affect the child's behavior (e.g., feeding, sleeping). They predict regressions in the child's development and how the parent will deal with them, based on their past coping strategies. Predictions that turn out to be false are as important as accurate predictions; both lay the foundation for increased future understanding of the child's capabilities and the parents' strengths and vulnerabilities.

Again, the seven-month Touchpoint Group offers an example of the value of predicting upcoming regressions in the child's behavior. The goal is for the parents, rather than the facilitator, to formulate possible solutions. Following a discussion of their babies' current sleep patterns, Ann focuses the parents on changes they can expect:

Ann: In the next few months, your babies will probably start having a hard time with separations. That means their sleeping may become disrupted and they may not want to separate and go to bed, or they may want you again in the night. How do you think you will handle it?

Karen: Well, I just can't close the door and walk away.

Yana: Yeah, my friend told me to just let her cry it out, but I don't know if that would work.

Kevin (to Ann): If you go in the room, though,

won't it just make it harder for the baby to go back to sleep again?

Rather than directly respond to Kevin's questions, Ann helps the parents find their own solutions.

Ann: Well, what's worked for you in the past?

Kevin: We just set up a regular routine, and that really seemed to help. We turn on the night light and some music, and he just knew it was time to go to sleep.

Karen: Well, when Rachel wasn't sleeping very well, we would go in and pat her on the back and then walk out. It took a few times, and it doesn't always work, but she usually went back to sleep.

Yana: My sister said that when her baby woke up a lot, she rocked her with a teddy bear and then put her down with it.

Ann decides to step in to label what the parents are describing without disturbing the flow of the discussion.

Ann: Do you know what that is called? It's called a transitional object. It's something that helps her make the transition from you.

Kevin: Someone else told us to give a teddy bear now, that that worked for them.

(Several other parents mention other approaches.)

Ann: I think you've all mentioned strategies that you've heard -- some feel comfortable to you and some don't. . . .

In an individual encounter with a professional, parents work out their individuality, while in a group, parents work out their commonality. In this discussion, the parents go through a process of deciding together what will work for them individually. They come to understand the meaning behind their baby's behavior and its meaning to them. On a deeper level, they discuss their concerns about their children feeling deserted or alone and how they feel about taking their children into their own beds.

For these parents, being armed with several strategies allows them to feel prepared and capable. If the child's sleep becomes disrupted again, they will be in a better position to handle it. Should the child's sleep problems not materialize, they will have gained in their self-confidence and feel they have contributed to the group. When oriented around the developmental challenges represented in the Touchpoints approach, parent gatherings go beyond comparing notes to establishing a vehicle for reframing parenting skills. The facilitator's role is to help parents anticipate their children's behaviors before the parents experience them. Parents can then join in the prediction process and identify solutions.

Implications for practice

The Touchpoints model can be used to enrich both individual and group encounters between parents and practitioners. In both contexts, the practitioner feels that she is part of a service delivery system that emphasizes anticipatory guidance and values relationships with parents. The Touchpoints Group approach offers the additional benefit of lessening the isolation that so many parents feel when their child's behavior becomes disorganized.

The Touchpoints approach also offers practitioners a framework for understanding the parallel processes of child and parent development. In the group process, with a facilitator who is well-versed in this approach, the shared passion of parenting helps parents focus and refine their parenting skills. The interaction that results among parents and practitioner becomes a powerful means to strengthen the system of care surrounding young children.

The Touchpoints model is not intended to stand alone as a "program," but is designed, rather, to be integrated into ongoing pediatric, early childhood, and family intervention services. Touchpoints Groups could be integrated into well-child care or become extensions of prenatal classes. The Touchpoints model lends itself to a multidisciplinary approach; group facilitators need not be health care professionals.

Given the current trend toward managed health care, Touchpoints Groups offer a unique opportunity to convey support and set up a network of continuing care around families of young children. Parents need and deserve to be heard. Parents and practitioners will benefit from a system of care built on strong relationships.

References

Brazelton, TB. (1992). *Touchpoints: Your Child's Emotional and Behavioral Development*. New York: Addison-Wesley.

Hear more
about innovations in pediatric primary care!

Register for Pre-Institute Seminar C
New Opportunities in Pediatric Primary Care: Moving beyond traditional boundaries
Kathryn E. Barnard, **R.N., Ph.D., University of Washington Seattle; *T. Berry Brazelton,* M.D., Children's Hospital Medical Center, Boston; *Margot Kaplan-Sanoff,* Ed.D., Boston City Hospital; *Ann Stadtler,* M.S.N., CPNP, Children's Hospital Medical Center, Boston**

at ZERO TO THREE's
National Training Institute!
Registration is limited.
For information, call, write, or fax:
ZERO TO THREE-NTI
P.O. Box 7270, McLean, VA 22106-7270
Telephone: 703-356-8300 • Fax: 703-790-7237

Bright Futures:
Health Supervision Guidelines and Their Implementation

Morris Green, M.D., Indiana University School of Medicine and
Meri McCoy-Thompson, M.A.L.D.
National Center for Education in Maternal and Child Health, Arlington, VA

As we approach the end of this century, several of the trends that affect children and families are intersecting with extensive changes in health care delivery. In the process, pediatric services are being transformed.

For millions of children, the future holds little promise. Their health status is poor; the risks to their health are many; and the prospects for overcoming these problems are limited. Family relationships are weakening and parents are spending less time with their children. Every year, divorce affects one million boys and girls. Over 25 percent of the nation's children live in one-parent households, and each year a million more newborns are born to unmarried mothers. Almost 11 million mothers with preschool children work outside the home, while one in four infants and toddlers is poor.

Health service policies, priorities, and professional education have not kept pace with these changes. Five years ago, the Maternal and Child Health Bureau of the Health Resources and Services Administration and the Medicaid Bureau of the Health Care Financing Administration launched the *Bright Futures* project, with the mission of developing health supervision guidelines responsive to the current and emerging needs of children and families.

Over 100 health professionals were convened to serve on a multidisciplinary board of directors, expert panels, and work groups. The four expert panels–one for infancy, early childhood, middle childhood, and adolescence–met over a period of three years to review the literature on disease prevention and health promotion and formulate recommendations. The draft guidelines were then sent out to 1000 reviewers, whose comments were incorporated into *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*, published in December, 1994 by the National Center for Education in Maternal and Child Health.

Bright Futures has been endorsed by 17 professional organizations and continues to gain recognition throughout the health community.

What makes *Bright Futures* unique?

- **Health is viewed comprehensively.** Unlike many pediatric texts and manuasl, *Bright Futures* takes a comprehensive view of children's health, encouraging health professionals and families to discuss the child's social relationships, emotional well-being and cognitive development as well as physical health and growth.
- **Health supervision is contextual.** The *Bright Futures* guidelines are concerned with the family and the community as well as with the child. Since health, educational, and social issues are strongly interrelated, they cannot be assessed in isolation from each other. *Bright Futures* recognizes the contextual forces on the child, including family, cultural, and economic variables, and challenges the health professional to note these variables as part of the child's world. Comprehensive, family-centered, and community-based health supervision requires that the child be viewed in the context of his or her family and community, and that health care be integrated with other human services.
- **Health supervision is a partnership between health professionals and families.** The Bright Futures guidelines are based on the belief that health supervision is most effective as part of an ongoing relationship between the health professional and the family. Over time, the health professional and the family build trust and are better able to discuss important issues. The essential task of the health professional is to reinforce the role of family as the child's educator, promoter of good health, and caregiver. Important health supervision goals include enhancing families' strengths, addressing their problems and vulnerabilities, building parental competence and confidence, and helping families share in the responsibility to prevent illness and promote health. Older children and adolescents are also viewed as partners in health supervision, assuming increasing responsibility for their own health as they mature.
- **Health supervision is a partnership between health professionals and the wider community**. The concepts of health supervision and health promotion reach beyond a visit to the health professional. Health supervision is a team effort, and depending on the environment in which various team members work, some of the components may even be addressed on a daily basis. Successful interventions often require efforts that extend beyond what can be provided in any one setting or through any one discipline. Health supervision can be provided in many settings, often with collaboration

between a variety of organizations and disciplines. Health supervision should be part of a seamless system, integrated with other health and human services, such as child care centers, early intervention programs, mental health services and public health programs.

- **Health supervision is individualized**. Every child and family are unique and will need to talk about different issues. The health professional helps address these issues while building on the strengths of the child, family, and community. While the Bright Futures periodicity schedule outlines the minimum number of visits from the prenatal period through age 21, children may need contingency health supervision visits at times of high family stress, such as moving, divorce, remarriage, death, major illness, and adoption or foster care placement. In addition, supplementary health supervision visits may be needed by children with special health care needs, those at risk of abuse and or neglect, those in families with multiple problems, or in foster care. Children should have health supervision tailored to their particular needs.

Highlights of *Bright Futures*

The Bright Futures guidelines are organized into four sections: infancy, early childhood, middle childhood, and adolescence. Each developmental section includes elements that provide an overview of the issues for that age period:

Theme chapter and chart of achievements

The first part of each developmental section provides an overview of the child during that developmental period. It includes a chart with a quick summary of the major achievements, tasks and desired outcomes for the child and family.

Preparation

Family preparation for health supervision visits is recommended by *Bright Futures* as a means to personalize the sessions and to make health supervision more efficient and effective. The health professional may ask a parent to write out, prior to the appointment, the questions, problems or other issues that the parent would like to have discussed. (Older children are also encouraged to prepare and write their own questions.) As another aspect of preparation, the health professional may request completion of a screening instrument, interim history sheet or a checklist of symptoms or problems. In addition, the parents may assemble the child's health passport, report cards, and school health forms to bring along for the visit.

Chart of strengths and issues

Every child has strengths as well as problems or issues. The family and the community have strengths that support the development of the child and issues that may cause problems for the child. Health supervision visits offer an opportunity to identify problems and to intervene early. The health professional can identify strengths during the interview and the observation that can help the child and family work through the problems.

Risk factors that may be identified include parental depression, marital problems, alcoholism, family violence, underdeveloped social supports, poor communication, inability to set limits, and lack of an understanding of a child's behavior. This chart can serve as a reminder of the many factors affecting development.

Health supervision summary

At the end of the health supervision visit, the health professional should go over the most important points of the encounter. Referrals can be discussed, as well as the best schedule for the next health supervision visit and what issues may be discussed.

Components of health supervision

The components of health supervision are presented as a package of services for each visit. While the physical examination, additional screening procedures, and immunizations are of critical importance in meeting our goals of successful health promotion, they are also the components of health supervision with which most clinicians already feel proficient. Health interview, developmental surveillance, observation and anticipatory guidance pose a greater challenge. These aspects of care traditionally have not been emphasized in a health professional's training or educational materials. In addition, these components of health supervision often require conversation about difficult or uncomfortable subjects, challenging even the most experienced health professional. *Bright Futures* makes its greatest contribution as a resource for health professionals to more thoughtfully incorporate these components into everyday practice and to enhance communication with parents.

Health supervision interview

The issues identified by the family are of primary importance, and health professionals can ask open-ended questions to elicit the concerns of children, adolescents and parents. In addition, it may be helpful to complement this information by selected "trigger" questions. Many people are hesitant to discuss family matters such as marital problems, violence, substance abuse or mental illness with their health professional lest they be viewed as inadequate. Many expect that health professionals will ask what they need to know. Many are unaware of the impact of family stresses and life events on children.

Trigger questions, to be asked selectively, include:

- How are you today?
- How are things going at home?
- Have there been any major stresses or changes in your family since your last visit?

- How are you balancing your role of partner and parent?
- Have you ever been in a relationship where you have been hurt, threatened or treated badly?
- How were things for you when you were growing up?
- Do you plan to raise your baby the way you were raised or somewhat differently?
- Who helps you with the baby?
- When are you planning to return to work?
- What do you enjoy most about your child?
- What do you do when problems seem to be getting to you?
- Do you and your partner tend to argue or differ somewhat in your ideas about discipline?
- Is there anything else that you would like to tell me?

Developmental surveillance

Instead of just checking off whether the child has achieved certain milestones, developmental surveillance involves collaborating with the family to observe the emergence of abilities in children over time. *Bright Futures* provides questions in several domains— communication, cognition, movement, social interaction and play—and describes a range of sample responses that parents may provide. For example, a health professional who has been providing health supervision to an eighteen month old child may ask the child's father, "Tell me about Jason's typical play." When the father replies, "He has some toys that he really likes. He can push his play lawnmower, likes playing ball with me, has started to build things with blocks, and is really starting to like crayons," the health professional can recognize the provided cues: "Imitates, has manual dexterity, and participates in social play."

Observation of parent-child interaction

In addition to physical examination of the child, observation of the child's behavior and of the parent-child interactions may provide useful information. Is the parent able to identify cues from her infant or child and respond consistently? Does the parent respond supportively to the infant's autonomy or independent behavior as long as it is not dangerous?

Anticipatory guidance

Anticipatory guidance is a highly important aspect of disease prevention and health promotion. The goal is to prepare the parents for the physical, social and emotional issues that may occur before the next visit. Anticipatory guidance may be given at appropriate points during the interview and physical examination or as part of the summary of the visit. Because it is not possible to provide comprehensive anticipatory guidance in the relatively short time usually available for health supervision, many professionals distribute handouts containing anticipatory guidance. Other settings use group or family anticipatory advice sessions.

Anticipatory guidance highlighted in *Bright Futures* include:
- promotion of healthy habits
- injury and violence prevention
- nutrition
- oral health
- sexuality education, among others
- promotion of social competence and mental health
- promotion of constructive family relationships
- promotion of community interactions.

Phase II: Building Bright Futures

When first volumes of *Bright Futures* rolled off the presses in December, 1994, all who had been involved in the development celebrated. But we knew our real work had just begun, and we knew we would need lots of help. In order to transform *Bright Futures* from an attractive publication into a working model on how to serve children and families, many partners would be needed. Fortunately, the collaborative development and review process meant many individuals and organizations were already familiar with the document and had begun using their copies of drafts to change their practice and programs even before *Bright Futures* was published. At the National Center for Education in Maternal and Child Health, our job for the past six months has been to encourage these efforts—providing technical assistance to people who are trying to implement the book's guidelines, connecting them with others who are undertaking similar efforts, sharing information at meetings and conferences across the country, and planning implementation materials.

How is Bright Futures changing practice?

Professionals are using *Bright Futures* as a personal resource, to help them shape their own relationships with families.

Cheryll Jones, ARNP, CPNP is a nurse at the University of Iowa Child Health Specialty Clinics. She has been in nursing for over 30 years, but Bright Futures is changing her practice. The trigger questions and anticipatory guidance sections are particularly helpful as she works to develop rapport with families and provide them with information about important topics.

John Meurer, MD, MM is an Associate Professor of Pediatrics at the Medical College of Wisconsin. He is working with the resident physicians in his program to develop health status questionnaires that families can complete prior to a health supervision visit. These questionnaires, which incorporate the trigger questions from *Bright Futures* help the families share all types of information so that the resident physicians can more effectively address concerns and questions.

Professionals are using *Bright Futures* to educate families.

In Richmond, Virginia, Fran Meyer and her colleagues at the Department of Education are developing parenting education modules based on *Bright Futures*.

Katie Cochran and her staff at Healthy and Ready to

Learn in Ewa Beach, Hawaii are using Bright Futures to create developmental charts for the families that they serve so they can better understand their child's development and behavior.

Bright Futures is being used as a bridge across programs and disciplines.

In Wisconsin, *Bright Futures* has been distributed to WIC programs, Head Start, local health departments, and birth to three programs. The content was also integrated into a manual for school nurses. To help with training, the Birth-to-Three program sponsored an audioconference and the Maternal and Child Health Education Training Institute a teleconference on *Bright Futures*, both broadcast to several locations around the state.

Keith Roberts, DDS, a pediatric dentist in Indiana, purchased two copies of the book as a gift for every pediatric primary care provider in his county. He is encouraging each provider to keep one copy as a personal reference and another in the waiting room as a reference for families.

Bright Futures is a tool that can change the way health professionals think. Over 250 medical and nursing schools have adopted *Bright Futures* as a required text. Physicians and nurses are using *Bright Futures* to provide continuing medical education to their colleagues.

Jerold Woodhead, MD, Clerkship Director for Pediatrics at the University of Iowa, provides a loaner copy to every student assigned to a General Clinics rotation. When students use *Bright Futures*, he focuses their attention on the components in any given chapter and asks them to reflect on the families they have seen and to prepare for the next day's visits. He has been impressed by the speed with which they incorporate developmental issues, screening and anticipatory guidance into their encounters with families. The students have also evaluated *Bright Futures* very positively.

In Texas, the department of health and the state nurse's association have developed a curriculum to certify nurses and physician assistants in Early and Periodic Screening, Diagnostic, and Treatment. Two days of the five-day course are developmental surveillance and anticipatory guidance, with material copied from *Bright Futures*. The trainers plan on training 800 nurses and physician assistants by December.

Bright Futures is influencing practice parameters, both at the state level and for professional organizations. The states of Alabama, Alaska, Colorado, Iowa, Maine, Missouri, North Dakota, Pennsylvania, South Dakota, and Wisconsin have each bought more than 100 copies to distribute within their programs.

The state of Florida has a legislative mandate to determine prevention practice parameters. *Bright Futures* is viewed as the model for pediatrics, and the chair of the committee is working to get *Bright Futures* adopted as the pediatric practice parameter.

The Advanced Practice Committee of the Society for Pediatric Nurses is using *Bright Futures* as a blueprint for redefining pediatric nursing. The committee would like to define standards and curriculum for advanced practice nursing, based largely on *Bright Futures*.

What are our plans for the future?

Part of our job is to get *Bright Futures* into the hands of those who are working with children and families. We are conducting a campaign to educate professionals about the document, presenting and exhibiting at national conferences and asking our many partners to include items in their journals, newsletters, catalogs, and professional presentations. In the next few months, *Bright Futures* will be available on CD-ROM and on NCEMCH's Home Page on the Internet.

We are using a database to track the expanding network of people using *Bright Futures* to be able to link people who are doing similar things. We also have a newsletter, *Bright Notes*, to keep people informed of the variety of ways *Bright Futures* is being implemented.

More importantly, we are in the process of creating materials to help professionals and families put *Bright Futures* into practice. For professionals, our first effort is *Bright Futures in Practice: Oral Health*, which will be published in the next few months. Other practice guides, on topics such as nutrition or mental health, are being considered. We also want to create tools for providers, such as a pocket guide, cue cards or medical chart sheets. Training modules will be developed for different professional disciplines.

For families, we would like to create materials that both provide information on child development and on how to get better help from their health professionals. Materials targeted directly at adolescents or parents of adolescents are being considered.

We are fortunate to have a public-private partnership that is growing every day to help make the development of these materials a reality. As this network grows we hope that more individuals and organizations can participate in these implementation activities, sharing expertise and opportunities for these materials to be evaluated in a variety of practice settings.

References

Green M., Kessel S.S. (1993). Diagnosing and Treating Health: Bright Futures. *Pediatrics*, 92: 998-1000.

Green M. (Ed). (1994). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Arlington, VA, National Center for Education in Maternal and Child Health.

Green M. *Bright Futures and the future of health supervision. Contemporary Pediatrics*, 11; 11:7.

Green M. (1995). No child is an island. Contextual Pediatrics and the "new" health supervision. *Pediatric Clinic N. Amer*, 42:79-87.

For additional information about the Bright Futures project, please contact Ms. Meri McCoy-Thompson at the National Center for Education in Maternal and Child Health via e-mail at ncemch01@gumedlib.dml.georgetown.edu or at (703) 524-7802. To order copies ($20 single copy plus $2.35 for shipping and handling; discounts available for bulk orders) contact:

National Maternal and Child Health Clearinghouse
2020 Chain Bridge Road, Suite 450
Vienna, VA 22181-2536.
(703) 821-8955 (ext. 254 or 265) 703-821-2098 (fax)

Keys to CaregivinG:

A new NCAST Program for health care providers and parents of newborns

Georgina Sumner, R.N., M.S.N.
NCAST, Seattle, Washington

In the majority of American hospitals today, mothers and their newborn infants are discharged only hours after delivery. Early discharge means that the family spends less time in an unfamiliar environment, and intimate contact between the baby and all family members occurs quickly. However, early discharge also means that just after a major physiological and psychological event, with no time for recovery, the mother returns home and may be expected to function as before, taking care of herself as well as the family.

Early discharge policies fail to consider that most new parents in this country are not aware of their baby's ability to interact as a social partner and to process what is going on in the immediate environment. Once they learn to understand and interpret the newborn's complex behavior, parents find that getting to know their infant is a marvelous experience. But who will teach new parents? Unfortunately, early discharge from the hospital and the reduction of "non-essential" services, such as anticipatory guidance and support, mean that hospital-based professionals no longer have the opportunity to teach new parents about their amazing newborn. Moreover, public health nurses, family physicians, community-based pediatricians, nurse practitioners, and lay home visitors, who now bear increasing responsibility for guiding new parents, may themselves have had little professional training in caring for newborns. These professionals may have a lot to learn about the past 40 years' discoveries about newborns' behavioral capacities.

The Keys to CaregivinG program was developed to teach both professionals and parents about newborn behavior and appropriate, responsive care. Keys to CaregivinG is the most recent initiative of the Nursing Child Assessment Satellite Training (NCAST) Programs, which has been using innovative methods to disseminate new information about infants and the role of caregiving for almost 20 years. In the late 1970's, Kathryn Barnard and her colleagues in nursing, developmental psychology, and pediatrics beamed instruction via satellite to maternal and child health nurses all over the United States. Satellite training focused on new research findings that confirmed the relationship of infants' early behavior and the caregiving environment to the child's subsequent cognitive development. Later, we formatted the scales of early parent-child interaction now known as the NCAST Feeding and Teaching Parent-Child Interaction scales (PCI) and taught them to nurse providers in hospitals, health departments, and university settings. Since the beginning of the scales' dissemination, more than 16,000 health care providers from all disciplines, in 48 states and 14 countries, have received NCAST training.

The Keys to CaregivinG program

Keys to CaregivinG is a learning package of six videotapes, a study guide, and booklets for parents. Designed to explain how and why newborn infants behave as they do, the series is based on many years of multidisciplinary scholarship, research, and practice. Although Keys to CaregivinG videos can be used in a self-study program, most learners prefer a group setting in which they can view and discuss the tapes with an instructor and their peers. Discussion helps to expand and solidify the meaning of the concepts introduced in the videos and study guide.

Designed to be viewed in sequence, the six videotapes show infants who were filmed in hospitals from two hours to two days after birth. We chose to focus on the newborn period to show how incredibly developed and capable babies are immediately following delivery. (In fact, many behaviors of newborns also occur in utero.) The videotapes cover infant state, infant behavior, infant cues, state modulation, feeding interaction, and professional/parent communication. Each videotape emphasizes one or two key concepts, each with direct implications for appropriate caregiving.

Infant state: An infant's state affects how the infant responds to a given event and may affect the care he receives. The infant's six states of consciousness (active and quiet sleep, three awake states, and one transitional state) are the basis for understanding infant behavior. This video offers vivid examples of each state, so that viewers with no prior knowledge of infant states can watch a newborn and recognize what state of sleep he is in, as he goes through alternating episodes of active and quiet sleep. Knowledge of the organization of a newborn's cycles of sleep and wakefulness is important for caregivers. For example, trying to feed an infant who is in a quiet sleep state is not a good idea; the baby will not suck or swallow well. If the caregiver waits five or ten

Jim Kurtz/ Agora Photos

minutes, however, the baby will transition automatically into an active sleep or drowsy state, when feeding is more appropriate.

Infant behavior: Knowing about infant behaviors helps caregivers respond more appropriately to the infant's needs. This video presents ten behaviors, adapted from the Brazelton Neonatal Behavioral Assessment Scale (NBAS), that parents find most rewarding in determining the care they give to their babies. These are: orientation to face and voice (alertness); orientation to face; orientation to voice; habituation; consolability; cuddliness; smiling; motor behavior; irritability; and readability. Four major considerations help guide caregivers in interpreting and responding to these behaviors.

1. *Infant state*—caregivers learn which states predictably elicit specific behavioral responses.

2. *Individual differences*—caregivers learn to identify unique behavioral expressions or patterns of responding that make a baby's behavior more predictable. For example, recognizing that her baby consoles quickly, cuddles easily, or resists being held helps a mother respond sensitively even to subtle differences, and gain confidence in her caregiving.

3. *Sensitivity of the caregiver*—caregivers learn how to bring about the best response from a baby. The "pacing" of an activity is important. For example, moving slowly and adapting to the infant's movements can be critical to eliciting desired behavior. Talking in soft, steady, continuous tones helps the infant to orient and respond to the caregiver's voice.

4. *The effects of infant behavior on caregivers*—knowing the infant's potential promotes positive interactions and feelings of competence in caregivers. Once parents know their baby can see and hear, they talk more and listen more to their baby. The newborn's behavior—and her caregivers' appreciation of its meaning—can be a powerful, long-lasting influence on important early relationships.

Infant cues: Cues are babies' ways of communicating with their caregivers. Babies use two types of non-verbal cues, engaging and disengaging; these, in turn, can be potent or subtle. Engaging cues communicate the desire to interact; they include smiling, looking at the caregiver's face, and reaching toward the caregiver. Disengaging cues, communicating the message, "I need a break," include crying, turning away from the caregiver, and falling asleep. Babies often use subtle cues before resorting to potent ones. When caregivers understand the newborn's "language," they can respond to subtle cues, enjoy their caregiving, and set up a rich communication pathway that can last a lifetime. In contrast, other babies are "taught to cry" before they receive a feeding by caregivers who do not respond to subtle disengaging cues.

State modulation: Infants use state modulation to deal with stimulation. Caregivers who use the principles of

BEST COPY AVAILABLE

state modulation find caregiving routines more pleasurable and rewarding. Sleep/wake cycles involve transitions during sleep (such as the transition from quiet to active sleep) as well as the transition from sleep to wakefulness. State modulation is the process an infant or adult uses to change from one state to another. Movement from one state to another and maintenance of a sleep cycle can be affected by both external stimulation (for example, noise, cold, loneliness) and internal stimuli (for example, hunger or discomfort). "Sleeping through the night" requires neurological growth to occur, but most three-month-old babies can begin to chain together enough sleep cycles to maintain sleep for at least six hours. Caregivers can help infants modulate state. To awaken a baby, use a variety of new and interesting stimuli in an active, but non-intrusive style. To soothe a crying or upset infant, use repetitious rocking, stroking, or talking in a soft, steady voice.

Feeding interaction: Feeding is more than just eating. It involves all the elements of state, behaviors, cues, and the modulation of states. Parents who are sensitive and responsive to infants' cues experience more pleasant, satisfying feeding interactions with their babies. Barnard's model of caregiver/infant interaction during feeding episodes looks at both the parent and the baby's responsibilities in the interaction. The parent's role involves: 1) the ability to recognize the infant's cues promptly; 2) the ability to soothe or quiet a distressed infant promptly and effectively; and 3) providing visual, motoric, and auditory experiences during the feeding that stimulate the baby's capacity to take in and respond to the environment. This can be as simple as encouraging the baby to explore the bottle, breast, or an object with eyes, hand, or mouth. The skills an infant needs for a successful feeding interaction include: 1) sending clear hunger cues to the caregiver by complete flexion of arms and legs, mouthing, active movement of extremities, hands over the stomach, and sucking movements; and 2) responding to the caregiver's actions by stopping crying in response to the caregiver's soothing attempts or looking in the direction of the caregiver's face when she talks.

Professional/parent communication: Assessment, sharing information, performance, and feedback are elements of a communication model that is satisfying for both professionals and parents. During assessment, the professional comes to know and understand parents' concerns, questions, and level of knowledge. Sharing information involves listening and responding to the parent's specific observations, questions, and concerns, and giving parents an opportunity to respond to the information provided — a "return demonstration" that reveals whether the information has been understood. Any successful learning process requires feedback. Commenting on and responding to the parent's performance gives validation and constructive information, motivates further efforts, and creates self-confidence. Positive feedback — for example, "The way you held Brendan close and patted him continuously really helped him to stop crying" — helps a parent become more aware of the impact of his caregiving behavior, reveals how the professional perceives his actions, and helps the parent feel part of a relationship in which someone cares for and about him.

Using Keys to CaregivinG in training

Although the Keys to CaregivinG program was developed originally for nurses, it has successfully helped a variety of professionals and parents provide responsive care for very young infants. Keys to CaregivinG has been used in hospital-based prenatal education programs, national prenatal education initiatives, health department clinics, free-standing clinics, WIC programs, and other perinatal care settings. Universities and community colleges are using Keys to CaregivinG in curricula designed for professionals who will be responsible for the care of very young infants.

The Keys to CaregivinG program can help all family members — including mothers, fathers, grandparents, and siblings — explore the information they already have about newborns and their care, and expand and enrich their knowledge. Showing the videotapes in a group setting and eliciting family members' values and beliefs about the concepts presented can help consolidate a shared understanding of infant behavior. This shared understanding, in turn, helps support sensitive, responsive, and growth-fostering caregiving.

Because parent education during the last trimester of pregnancy tends to focus on the labor and delivery process, we recommend presenting the Keys to CaregivinG video series to expectant parents in the sixth or seventh month of pregnancy. Both first-time and experienced parents find the series helpful. Experienced parents often comment, "If I had only known this when I had my first child!"

Professionals who come into contact with new parents only after delivery should share Keys to CaregivinG with family members during the first month postpartum. Establishing a strong professional/parent relationship is the first priority; the information contained in Keys to CaregivinG should be shared initially in face-to-face dialogue. To reinforce — but never to replace — dialogue, booklets for parents, in English and Spanish and written at a 4-6th grade reading level, are part of the Keys to CaregivinG learning package. Booklets address the concepts of infant state, infant behavior, infant cues, state modulation, and parent-infant interaction.

Readers who are interested in bringing NCAST training programs to their community may call the NCAST Program office in Seattle, Washington, tel: (206) 543-8528.

Publications

Developmental and Behavioral Pediatrics: A Handbook for Primary Care (1995) - Steven Parker and Barry Zuckerman (Little, Brown and Company, Boston, MA 02108) $39.95.

Primary care clinicians are most effective, the editors of this volume suggest, when they can form therapeutic alliances with children and families; sensitively elicit information; understand the psychological, biological, and social roots of problems; and have ready concrete, practical, and effective treatment strategies. This 89-chapter handbook is designed as a user-friendly tool to strengthen such skills among pediatricians, family practitioners, nurse practitioners, physicians' assistants, pediatric nurses, and others who care for children.

Part I discusses the fundamentals of behavioral and developmental pediatrics, with chapters covering such topics as establishing a therapeutic alliance, interviewing, diagnosis, and management. Contributing authors include, among others, T. Berry Brazelton, Jack P. Shonkoff, and Yvette E. Yatchmink.

Parts II and III address issue-specific developmental and behavioral problems and family issues, ranging from biting and sleep problems to witnessing violence to cultural responses to behavioral problems. Authors contributing to these sections include, among others, Stanley I. Greenspan, Barry Zuckerman, Deborah Frank, Susan Coates, Ilgi Ertem, James A. Blackman, Robert Needlman, Betsy McAlister Groves, Teresa M. Kohlenberg, and Lucy Osborn. Appendixes include behavior and symptom checklists and developmental milestone charts.

Starting Right: How America Neglects Its Youngest Children and What We Can Do About It (1995) - Sheila B. Kamerman and Alfred J. Kahn (Oxford University Press, Inc., 198 Madison Avenue, New York, New York 10016) $25.00.

No one stage of life is more important for shaping an individual's future development and life course than are the first three years, observe Sheila Kamerman and Alfred Kahn. Yet America's infants and toddlers are in trouble, and their situation is changing dramatically for the worse: Among other indicators, during the 1980s, the number of poor infants and toddlers increased by 26 percent, and in some cities and rural areas over 45 percent of infants and toddlers live in poverty.

A 0-3 policy agenda must address economic security, time for parenting, maternal and child health, and services (including both infant and toddler care and education and family support services). Drawing on their extensive study of northern and western European countries which have developed a variety of policy options supportive of families with children under three, as well as U.S. models, Kamerman and Kahn review strategies including child or family allowances and tax benefits, child support insurance, housing, maternity and parental leaves, infant and toddler child care, home visiting, and community family resource centers.

Reviewing possibilities for reform in child health care, the authors argue that since "a complex intertwining of nutrition, housing, poverty, parental competence, parental health, and life-styles determine child outcomes,...medical supports and interventions must come from staff and a delivery system with a broad view of child development and a readiness to initiate other-than-narrow medical interventions." Child health supervision is critical, supported by outreach and linked to a range of other supports for infants, toddlers, and their families.

Community Child Health: An Action Plan for Today (1994) - Judith S. Palfrey, foreword by Julius Richmond (Greenwood Publishing Group, 88 Post Road West, Box 5007, Westport, CT 06881) $55.00.

To address the health problems that affect America's children, antibiotics and vaccines are no longer enough; child health professionals must redirect energy toward healing children's ills in the context of their families and communities. Judith Palfrey elaborates this theme, drawing on her clinical and research experience at the Children's Hospital in Boston, as she examines children in a changing community context, community influences on children's health, and trends in the health status of American children. The volume discusses constraints that have limited community outreach by child health practitioners and describes issues and guidelines in providing health care services for children at social risk and for children in group care. A final section describes steps toward an integrated service delivery system at the community level.

Strategies To Enhance Preventive and Primary Care Services for High-Risk Children in Health Maintenance Organizations (June, 1995) - Margaret A. McManus and Harriette B. Fox (The Child and Adolescent Health Policy Center, George Washington University, Washington, D.C.) Available by calling Jennifer Dunbar at McManus Health Policy, tel: (202) 686-4797. $25.00.

This report, prepared with funding from the federal Maternal and Child Health Bureau, DHHS, is designed for medical directors, pediatric health professionals, and quality assurance staff of Health Maintenance Organizations (HMOs), and for the purchasers of managed care services, including both private sector employees and state Medicaid agency officials. It argues that HMOS, because of their unique emphasis on early detection and treatment, have an important role to play in serving the large and growing number of children who are at risk of developmental, behavioral and emotional, and physical health problems because of environmental, behavioral, and biological risk factors.

The report describes 15 design elements, related to

needs assessment, access initiatives, and enhanced preventive and primary care, that HMOs can integrate into existing program operations in order to improve long-term outcomes for high-risk children. The report defines each design feature, discusses implementation issues, and presents illustrative examples. These elements include enriched case management services (assigning a nurse, social worker, or other professional to a very high-risk child and family); assigning high-risk children to primary care providers who have, or have regular access to, special expertise in areas such as behavioral-developmental pediatrics or chronic illness management; and the co-location of mental health professionals in primary care settings, either as consultants to the pediatrician or family physician, as providers of short-term treatment, or as organizers of family support and education groups.

A Welcome for Every Child: How France Protects Maternal and Child Health — A New Frame of Reference for the United States (1994) - Gail Richardson (a report of the French-American Foundation published by the National Center for Education in Maternal and Child Health (The French-American Foundation, 41 East 72nd Street, New York, NY 10021) $10.00.

This publication contains the joint findings of the French-American Foundation's investigation of the French maternal and child health system and of 13 American health care practitioners and policy makers who observed French physicians, midwives, and nurses at work in neighborhood health centers, hospitals, preschools, child care centers, administrative bureaucracies, and homes. The delegation, which included C. Arden Miller and Barry Zuckerman, noted that France is facing challenges similar to those faced by the United States, resulting from rising medical expenditures and growing social problems linked to unemployment and poverty. However, 96 percent of French children are born to mothers who received early prenatal care. Only 4.6 percent of French children live in poverty. All but a minuscule fraction of French children live in families that receive universal health insurance, paid maternity leaves, and family allowances to help meet the costs and responsibilities of childrearing. By age two, more than 90 percent of French children receive all required immunizations.

Recommendations based on the French experience would: 1) remove barriers of cost, eligibility, distance, and stigma that prevent families from entering doctors' offices and other medical settings to receive preventive exams, tests, and vaccinations; exercise vigilance and do outreach, neighborhood by neighborhood, to identify women and children at risk while there is still time to help families take responsibility for solving their own problems; adjust working conditions and hours for pregnant women to reduce stress and the likelihood of preterm delivery, and offer paid maternity and other parental leaves, with job security, to permit families time to nurture very young children; and create specific expectations for families regarding their responsibilities to the next generation, and offer respect, incentives, and information to promote the fulfillment of these obligations.

Investing in a Healthy Future: A How-To Manual for Effective Maternal and Child Health Programs (1995) - The Association of Junior Leagues International, Inc. (AJLI Resource Department, 660 First Avenue, New York, NY 10016-3241) $25.00.

This handbook was developed to help community-based organizations improve the lives of pregnant women and children by effectively addressing their health needs. The publication provides an overview of the current maternal and child health situation in Canada, Great Britain, Mexico, and the United States. It provides specific information on how to work in a multicultural setting, establish or revitalize community advisory boards, assess maternal and child health needs, and plan, implement, and institutionalize community programs. Case studies of League initiatives in Arlington, Fort Worth, Minneapolis, and Stamford-Norwalk illustrate these strategies.

Videotapes

The Ages & Stages Questionnaires on a Home Visit. 22 min. with The Ages & Stages Questionnaires (ASQ) system - including User's Guide, questionnaires (English or Spanish) and scoring sheets - are components of The Ages & Stages Questionnaires: A Parent-Completed, Child-Monitoring System. ASQ was developed by Diane Bricker, Jane Squires, Linda Mounts, LaWanda Potter, Robert Nickel and Jane Farrell. Published and distributed by Paul H. Brookes Publishing Co., Inc., P.O. Box 10624, Baltimore, MD. 21285-0624, tel. 800-638-3775. Also available from Child Development Media, Inc. 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel. 800-405-8942. $175 for the set.

ASQ is a screening and tracking program for infants and young children who are at risk for developmental delays. This parent-completed child-monitoring system is designed to identify infants and young children who require further developmental evaluation. The questionnaires are designed to be completed by parents when a child is 4, 8, 12, 16, 20, 24, 30, 36 and 48 months of age with optional questionnaires available at 6 and 18 months. This screening tool helps to identify children who may need further diagnostic testing and intervention services. The screening tool can also be used to monitor children who are likely to outgrow their problems naturally without intervention. The Ages & Stages Questionnaires on a Home Visit video tape is a companion to the ASQ and shows a home visit with a fam-

ily who have three children. The home visitor guides the family through the questionnaire items and demonstrates how to explain the screening process to parents; create opportunities for children to demonstrate skills; encourage siblings and other family members to participate; redefine items to reflect a family's values and culture; and promote parent-child interaction and optimum child development. The tape also offers suggestions on scoring ASQ during the visit, on activities for parents to implement with their children and suggests leaving additional questionnaires with the family. Accompanying discussion questions can facilitate the training of home visitors and other service providers to use ASQ.

Listening to Families Videotapes:

This series is designed to meet the growing need for training early interventionists to work effectively with families. Produced by Jana Staton, Ph.D., American Association for Marriage and Family Therapy Foundation Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA, 91401. Tel. 800-405-8942. Individually priced, or 16 tape series/$700 (plus shipping and handling).

Introductory Tapes: Created for use with providers working with families in a variety of settings, including IDEA Part H services, Head Start, family preservation, maternal and child health and marriage and family therapy. The tapes focus on the provider's role of engaging families in conversations to build a partnership and on listening to and eliciting family strengths rather than a focus on problems.

Building a Family Partnership. 50 min. Viewers Guide included. $75.
This tape includes unedited excerpts from conversations with five diverse families. Segments were selected to highlight generic communication strategies helpful in joining with a family and building a collaborative partnership. Strategies include: having a conversation rather than an interview, sharing power by letting the family do the talking, focusing on family members' strengths, asking open-ended questions and encouraging expression of different viewpoints. Experienced family consultants meet with families from African-American, Hispanic/Latina and European-American backgrounds from all income levels.

Exploring Family Strengths. 30 min. Viewers Guide included. $75.

This is a highly focused presentation of the rationale, examples and strategies for engaging families in conversations about their strengths as well as their problems. The video explains why recognizing family strengths is essential to building a family partnership, demonstrates the essential importance of the provider's belief that all families have strengths, and illustrates how early interventionists can explore and elicit strengths with families from diverse economic and cultural backgrounds, even under difficult and stressful circumstances. All the families and family therapists from the Listening to Families series are shown.

Individual Family Videotapes: Conversations with individual families explore the issues of raising a young child or children with special needs. Families are from diverse cultural, linguistic and economic backgrounds with children representing a wide range of disabilities, talking with experienced family therapists who demonstrate how to listen to a family's story and focus on family concerns, priorities and resources.

Two- tape sets (second tapes shows follow-up visit one year later): $80 ea. set. (plus shipping & handling)

Colton Family: A Family Fighting for Its Vision of Carissa with Colton Family: One Year Later
Two parents, three children. The one-year-old daughter has Down syndrome; the boys are six and 11. The focus is on family hopes and vision for Carissa in contrast to that of some providers, family decision making and interactions, needs of the older children, the role of brothers in caring for their little sister, and strengths from religious faith and extended family. Family is middle-income, African-American, Setting: family home. Family Consultant: Jana Staton, Ph.D.

Dutton Family: Two Wise Women Demonstrate Strengths of Intergenerational Parenting Team with Dutton Family: One Year Later
Mother and grandmother, and three children, two-, three- and four-years-old. The three-year-old boy has cerebral palsy. The focus is on strengths of shared caregiving, the family's hopes for the child, tensions between mother and grandmother over discipline and family rules, difficulties with getting EI services and making the transition from Part H to public schooling. The family is limited-income, African-American. Setting: church parlor. Family Consultant: Lee Combrinck-Graham, MD.

King Family: When Support Isn't Enough with King Family: One Year Later
Mother, father and two children, a girl, two-and-a-half and a boy, four. The younger child has C-H-A-R-G-E, a syndrome with multiple birth defects affecting major organ systems. The focus is on parenting roles, stress on the parents and their relationship from caring for a medically fragile child, the needs of the older sibling, interactions with medical and EI providers, conflicts over diagnosis and treatment and financial and future concerns. The family is middle-income, European-American. Setting: family home. Family Consultant: Lee Combrinck-Graham, MD.

Single tape titles: 60 min. ea. With discussion guide. $60 ea. tape (plus shipping & handling).

Andreas Family: Parents Set Aside Differences and Work Together for the Sake of Their Child
Mother, father, one child. The son is two years old, and was born with multiple congenital malformations, including Dandy-Walker syndrome, cerebral palsy, hydrocephaly. The focus is on the parents' commitment to their child and efforts to cooperate although they are now separated, difficulties of getting respite care in a rural area, and the attitudes of the family and its town toward a child with severe disabilities. The family is working class, European-American. Setting: family home. Family Consultant: Eric McCollum, Ph.D.

Bernardo Family: Parental Intuition Makes the Difference for Child with an Ambiguous Diagnosis
Mother, father, two children, two and four years old. The oldest boy has speech delays and possible diagnosis of ADD. The focus is on the parents' difficulties and stress in decision making when the diagnosis is uncertain or ambiguous, the parents' sensitivity toward their child's needs, parental differences over advice not to use native language in the home (Spanish) because of speech difficulties, financial concerns due to mother working only part-time in order to meet child's needs. Family is middle-income, Latino. Setting: family home. Family Consultant: Halcyone Bohen, Ph.D.

Bond Family: Love Changes Everything: A Young Couple Forms a New Family
Mother, father and five children. Only the two-year-old son, born prematurely with hydrocephaly and developmental delays, is present. The focus is on the development of a couple bond, family-of-origin relationships and acceptance, medical and EI services and hopes for the future. The parents, a young working couple, are middle-income, African-American. Setting: office. Family Consultant: Wayne Jones, Ph.D.

Espinoza Family: Keeping the Diagnosis from Taking Over the Family
Mother, sister and mother's best friend, with only child, a boy, six-years-old. (Husband/father was working and could not be present) The boy was diagnosed with autism at four after diagnosis of PDD in infancy. The focus is on the family value of inclusion in family like and in education, differences in parents' roles in child-rearing, support from sister and friend in providing care, family attitudes toward diagnosis of autism and confronting attitudes within Latino culture toward children with special needs. Family is middle-income. Latino. Setting: studio. Family Consultants: Wayne Jones, Ph.D. and Tawara Taylor, M.A.

Johnson Family: Love Across the Generations: Grandmothers Caring for Grandchildren
Grandmother and great-grandmother. three children. The children are two, three and four, born to a drug-abusing mother, who no longer lives at home. All three children have developmental delays; one had seizures,. Their EI home visitor and a family neighbor/friend also join in the conversation. The focus is on family strengths, differences in child-rearing philosophy across generations, impact of drugs on family life and continuity, importance of extended family, friends, social services and spiritual values. The family is limited-income, African-American. Setting: family home. Family Consultant: Nancy Boyd-Franklin, Ph.D.

Rivas Family: Hopes of a Strong Immigrant Family on Fragile Ground (in Spanish, with subtitles)
Mother, father, four children. The two boys, five and seven, have sex-linked mental retardation; the girls are 14 months and four-years-old. The parents are from rural El Salvador. The focus is on the family's hopes for the children, the parents' understanding of the boys' disabilities and abilities, EI services available, parents' employment difficulties and support from extended family and church community. Family is limited-income, Latino. Setting: family home. Family Consultant: Elena Cohen, MSW.

Thompson Family: Hanging in There: Two Generations with Altered Priorities
A single father and his parents. The child a boy of 18 months, has serious asthma: he was ill and not able to participate. The father has returned to live with his parents, who share in care-giving for their grandson. The focus is on the boy's medical condition, attitudes of medical staff towards the family, financial difficulties, communication, and tensions over shared responsibilities and altered priorities of grandparents. The family is middle-class, European-American. Setting: church parlor. Family Consultant: Eric McCollum, Ph.D.

Williams Family: Strength and Vulnerability in a Family with Many Concerns
Young mother, her mother, two children, four and almost three, and mother's niece, seven months. The three-year-old son has been diagnosed with neurofibromatosis. The focus is on family strength and vulnerabilities, multiple caregiving demands brought on by the mother's worsening sickle cell anemia, the three-year-olds special needs and EI services, custody issues with niece, strengths and support of African-American family, community and church, the mother's hopes for future for herself and her children. Family is limited-income, African-American. Setting: family home. Family Consultant: Harry Aponte. ACSW.

ZERO TO THREE

is published 6 times per year. Subscriptions cost $37 per year, $69 for 2 years and $99 for 3 years. Subscribers may order additional copies of **Zero to Three** for distribution to staff or students at a rate of $20/auxiliary subscription/year. **Zero to Three**'s federal ID# is 52-1105189. Telephone orders may be placed by calling 1-800-899-4301.

☐ I would like to subscribe to **Zero to Three** for
___ 1 year ($37) ___ 2 years ($69) ___ 3 years ($99)

☐ In addition to my subscription, I would like to order
___ auxiliary subscriptions at $20 each per year.
I understand all copies will be mailed to me.

☐ Please send me a complete **ZERO TO THREE** publications catalog.

☐ In addition to my subscription.
I would like to contribute _____ to support the work of **ZERO TO THREE**/ National Center for Clinical Infant Programs. Contributions are tax deductible.

☐ Charge to
___ American Express ___ Master Card ___ Visa

Name on credit card _____

Account No. _____

Expiration Date _____

Signature _____

☐ Enclosed is my check for _____
Payable to **ZERO TO THREE**.

Send to:
ZERO TO THREE/National Center for Clinical Infant Programs
PO Box 25494
Richmond, VA 23260-5494

Name _____

Mailing Address _____

_____

City _____

State _____ Zip _____

Professional Discipline _____

_____

_____

ZERO
TO
THREE
2000 14th Street North, Suite 380, Arlington, VA 22201-2500

Address correction requested

Non Profit Org.
US Postage
PAID
Washington, DC
Permit No. 2516

Moving
Be sure to notify **Zero to Three** of your new address.
Third class mail is not automatically forwarded.

41

BEST COPY AVAILABLE